MEDICAID CAPITATED MANAGED CARE PROGRAM FOR SSI DISABLED

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Executive Summary

Persons with disabilities receiving SSI benefits account for a disproportionate share of Medicaid expenditures. In 1992, when the study described here was conducted, SSI beneficiaries with disabilities constituted about 15 percent of the Medicaid population, but accounted for 36 percent of Medicaid expenditures. State policymakers, in an effort to control these disproportionate expenditures, have enrolled Medicaid recipients in managed care plans. At the outset of our study, sixteen states enrolled the SSI-Disabled population in Medicaid managed care plans. In the pages that follow, we describe one of the first attempts to understand more about the state policies that are promoting managed care enrollment for working age adults with disabilities, and plan administrator perceptions about this trend.

We gathered information about the SSI-Disabled population and Medicaid managed care plans from several sources. First, a brief survey was mailed to all 50 states and the District of Columbia, asking the state Medicaid Director or his or her designee to provide information about the enrollment of the SSI-Disabled population in Medicaid managed care plans. Survey results indicated that 16 states enrolled the SSI-Disabled population in a managed care plan. These managed care plans represented a variety of financing and service delivery models, including fully capitated plans, Primary Care Case Management models and other configurations.

We selected eight of the sixteen states for site visits. The eight states were purposively selected to represent variation along a number of characteristics including geographic distribution, plan type, reimbursement model, size of the Medicaid population, enrollment type and degree of Medicaid recipient enrollment in managed care. The eight states selected for site visit included California, Colorado, Florida, Kansas, Maryland, Michigan, North Carolina and Utah. Research teams of at least two persons visited each state to conduct interviews with state policymakers and program administrators and to gather and review relevant documents related to Medicaid managed care plans and the SSI-Disabled population.

In addition to the mailed survey and the site visits, we also gathered data from a 1993 mailed/telephone follow-up survey of administrators of all capitated plans that enroll the SSI-Disabled population, in all states. There were 118 capitated plans dispersed across 12 states. Of this sample, seven were subsequently determined to be inappropriate for the sample, because they did not enroll the adult working-age SSI-Disabled population. Of the remaining plans, 80 administrators responded to the survey.

All of the states included in the site visit sample had started their Medicaid managed care plan under a 1915 (b) waiver. The site visits revealed that states approach Medicaid managed care for the SSI-Disabled population in a variety of ways. Some states, such as Michigan had been enrolling the SSI-Disabled population in Medicaid managed care plans for some time. Others, such as North Carolina, has just begun to develop managed care options. Often a single state would offer more than one managed care options for Medicaid recipients.

It was typical for states to begin managed care plan development with HMO's. As the risk issues involved with serving the SSI-Disabled population became more evident, however, states became more likely to promote the development of fee-for-service based models, such as Primary Care Case Management Programs. A range of SSI-Disabled recipients were enrolled in managed care plans, from a low of four percent in Florida, to a high of 76 percent in Maryland. Although most plans offered SSI-Disabled recipients a range of services, these were likely to include only those services that were already offered in the state's Medicaid plan, and were less likely to include services such as personal care or respite services.

Although most states had mandatory managed care enrollment for Medicaid recipients, sub-populations, such as recipients in institutions were likely to be excluded. Moreover, some states excluded recipients on a case-by-case basis, if program administrators believed the recipient would be better served in the traditional fee-for-service system. In some states, case-by-case exclusions were common.

Managed care plans are reimbursed by states using a variety of mechanisms. Primary Care Managers are often given a case management fee on a per member per month basis, although Utah had already stopped this practice, and Kansas interviewees suggested the case management fee was not sufficient to effect provider participation. Most fully capitated plans received rates that were adjusted for age, gender, and disability category. The capitation rate for the SSI-Disabled population was often three to four times higher than the AFDC rate. States sometimes offered reinsurance to plans, but other states neither required reinsurance or provided it. Some partially capitated plans were operating in California. Primary Care Case Management programs were typically not under financial risk arrangements.

Quality of care in the managed care plans was monitored by typical methods including enrollee grievance procedures, monitoring of disenrollment trends, and some enrollee satisfaction surveys. Plan disenrollment was low, but this was due, in part, to the mandatory enrollment policies. A variety of mechanisms were used to control utilization, including, prior approval, PRO's and second surgical opinions. The states gathered little data on person specific utilization, and had little idea about utilization differences among sub-populations of persons with disabilities, such as those with cognitive disabilities versus individuals with physical disabilities.

The results of the health plan administrators survey suggest that capitated plans are likely to be private, and are slightly more likely to have voluntary than mandatory enrollment. The plans offer a range of traditional services, including traditional therapies and acute care services. Most plans enroll the SSI-Disabled population in order to comply with a state mandate, and a minority of plans are able to negotiate capitation rates with the state. A majority of plans see barriers to enrolling the SSI-Disabled population in managed care, but most plans can mention at least one aspect of the plan that seems to be working well. A majority of the capitated plans are not considering increasing their participation in the Medicaid program.

Together, these results suggest that there is considerable variation among and within states in the development and implementation of Medicaid managed care models for persons with disabilities. However, there is no one model that appears to be superior to the others, and the use of capitated models for the SSI-Disabled populations has not been well tested. It appears that administrators of fully capitated plans have no intention of significantly increasing enrollment of the SSI-Disabled population. For this reason, states are turning to Primary Care Case Management models to enroll the SSI-Disabled population.

Although these results provide some insight into provider and policymaker attitudes toward the enrollment of persons with disabilities in managed care plans, there is a lack of basic information about the service needs of people with disabilities, and how these needs vary across sub-groups of individuals with disabilities. In order to further promote the development of managed care plans for people with disabilities, states would be well advised to learn more about the demographic characteristics and the utilization and cost experiences of these populations, in order to remove some of the uncertainty involved with providing services under a risk-based model. Moreover, states may wish to consider promoting the development of managed care models using providers with experience in serving this population.

1. Introduction

For more than 20 years, rapidly rising costs have kept the United States' health care system in a chronic state of financial crisis. In 1988, spending for national health care amounted to 11.1 percent of the gross national product (GNP); more than twice the share it commanded in 1960. In 1993 health spending was even higher, reaching 15.1 percent of the GNP. The Commerce Department expects that if this pattern is maintained, spending for health care will increase at an annual rate of 12 to 15 percent over the next four years. Intensifying these increases in overall spending for health care has been the dramatic growth in total Medicaid expenditures. From 1975 to 1990, total Medicaid payments grew from $12.2 billion to $66 billion (Reilly, Clauser & Baugh, 1990). From 1990 to 1992, national Medicaid expenditures increased by 40 percent and totalled more than $90.8 billion (HCFA-2082, December 21, 1993).

Contributing to the growth in Medicaid expenditures are payments to adults with disabilities who receive Supplemental Security Income (SSI) and are therefore eligible for Medicaid health care benefits. Although the number of SSI recipients has grown (rapidly) over the past 20 years, Medicaid expenditures for this group have increased even faster. In 1974, 2.4 million individuals received approximately $3.1 billion in Medicaid benefits. Almost 20 years later, nearly 4 million received more than 9 times this amount, nearly $28 billion (Piltch, Batten, & Drainoni, 1993). Moreover, persons with disabilities receiving SSI benefits account for a disproportionate share of Medicaid expenditures. In 1992, SSI beneficiaries with disabilities constituted about 15 percent of the Medicaid population but accounted for 36 percent of Medicaid expenditures (Urban Institute, 1993). Thus the cost consequences to Medicaid of SSI recipients have been enormous. Federal and state policymakers and health care providers are aware that individuals with serious disabilities are likely to have higher health care expenditures, and they are searching for better ways to manage these costs.

One key to controlling costs has been managed health care, a coordinating and rationing strategy designed to make the "gatekeeping" role of a primary care professional the key to regulating health care costs (Friedman, 1993; Bachman, 1992; Freund & Hurley, 1987). Following the lead of the private sector in instituting managed care plans, the federal government has promoted state-level development of Medicaid managed care plans. (See Literature Review in the Appendix (Friedman, 1993) for a full discussion of the history of the development of managed care in the public sector.) Although Medicaid managed care enrollment rates are lower than enrollment in managed care in the private sector (Booth, Coburn & Riley, 1993; Iglehart, 1992; Moley, 1992), they have increased progressively during the last decade to about 12 percent of all Medicaid recipients. An estimated 45 percent of these beneficiaries are enrolled in managed care fee-for-service programs, 34 percent in HMOs and 19 percent in a range of other managed care models (Shikles, 1992).

1.1 Types of Medicaid Managed Care

The managed care plans that have been offered to the Medicaid population differ along two major dimensions: payment approach and enrollment model. First, programs can

be distinguished across a continuum of prepayment versus fee-for-service payment strategies. The range of payment methods includes fee-for service, fee-for-service plus case managed (CM) fee, fee-for-service with shared savings, capitation with shared savings and full capitation. Hurley & Freund (1991) have classified the Medicaid managed care programs they examined into 3 major typologies by payment method:

Type 1--a fee-for-service primary care case manager (PCCM) model;
Type 2--an at risk (capitation) PCCM model; and
Type 3--a prepaid (capitation) health plan model.

In the Type 1 fee-for-service PCCM arrangement, the state Medicaid agency or Health Insurance Organization (HIO) contracts with individual physicians or physician groups to provide primary care to Medicaid recipients and to authorize (as a "gatekeeper") all other covered services provided by others. Typically, payment is fee-for-service and contracting physicians are provided an additional case management fee.

The Type 2 at risk (capitation) PCCM arrangement involves some risk-sharing for contracted physicians/physician groups via capitation payments for primary care services and sharing in losses or gains related to use of outside providers services. Payment for inpatient services are often fee-for-service. The Type 3 arrangement, the prepaid health plan model, involves the assumption of full responsibility for all covered services by prepaid health plan organizations (HMOs). HMOs are the original and most widespread type of Medicaid managed care prepayment program.

A second dimension of Medicaid managed care programs pertains to the enrollment model which may be either voluntary or mandatory. In some states, Medicaid recipients can choose whether or not they want to participate in a managed care program. In other states, Medicaid enrollees are required to participate, although they may frequently choose from among more than one plan option. Further, in some states, participation is only mandatory for selected categories of Medicaid recipients or for persons in particular geographic areas (HCFA, 1992).

1.2 Evaluations of Medicaid Managed Care Programs

The majority of evaluations of managed care plans have been about plans that were a benefit of full-time employment and were used by a relatively young and healthy population (Friedman, 1993). Hurley and Freund (1991) assessed studies of the impact of managed care on the Medicaid population and found these studies have been of limited quality. Despite the shortcomings of these studies, they found that:

1. Medicaid expenditures were reduced in 80 percent of the programs.

2. Managed care programs led to decreased use of emergency services, ancillary care, prescription drugs, and inpatient care.

3. Service use was higher for physician visits in fee-for-service models compared to the capitated models.

4. Few differences in service use were detected between voluntary and mandatory programs.

5. Cost savings were more often reported in mandatory than voluntary programs.

Hurley and Freund (1991) and other researchers (Heinen et al., 1990; Riley et al., 1990; Shikles 1992) have identified a multitude of pressing research and policy issues in need of further scientific investigation and national attention with respect to the impact of Medicaid managed care on consumers, providers and administering agencies. These include: quality of care; standardized data collection and management systems; quality assurance standards and monitoring mechanisms; provider and beneficiary recruitment; continuity of eligibility; examination of the presence of biased selection enrollment patterns; rate-setting strategies including stop-loss protections for providers; consumer satisfaction; and, service approaches with consumers having complex health and social needs, particularly in the nation's urban areas.

1.3 Managed Care for SSI Recipients

Research is even more limited regarding the effectiveness of managed care for special populations, specifically, Supplemental Security Income (SSI) recipients of working age, enrolled in Medicaid managed care programs. However, the unique health and social needs of this group underscore the necessity for understanding the effectiveness of managed care approaches for serving them. Persons with disabilities often have established relationships with multiple specialists and may be willing to join a managed care plan only if these ties can be maintained (Heinen et al., 1990). They may have special needs which can best be served by specialists not associated with available managed care plans (Riley et al., 1990). Established HMOs may have limited experience dealing with Medicaid recipients having mental and/or physical disabilities (Anderson & Fox, 1987). In capitated programs, plan administrators may be concerned about high utilization and financial risk (Group Health Association of America, 1990). This difficulty is often compounded by a lack of sufficient cost and utilization data (Batavia et al., 1989). Since approximately 40-45 percent of persons in this special population also receive Medicare (Adams, Ellwood & Pines, 1989), the financial management of a capitated program fully responsible for their health care needs is further complicated. Beyond the logistics of implementation, questions arise about how well these persons can be served in managed care programs as their health care needs often differ in critical ways from those of the general population (Meyers, 1990). In addition, clarity

regarding how well managed care programs can serve individuals with chronic, as well as acute, health care problems is critical.

The three largest adult SSI disability categories include persons with mental retardation/developmental disabilities (26.5 percent), mental illness (27.4 percent) and physical disability (46.1 percent) (Piltch, Batten & Drainoni, 1993). Similarities and differences are present in the needs of these three populations. For example, a substantial portion of individuals in each of these groups requires a range of health-related services much broader than those generally classified under acute care. Of particular relevance for those with developmental and physical disabilities are ongoing maintenance services, such as, occupational therapy, language therapy, physical therapy, personal assistance services, durable medical equipment and assistive devices. These services are generally not well covered under private insurance plans and Medicaid programs vary tremendously in their coverage of these services (Henderson, Howard & Strickler, 1991).

The treatment of serious and persistent mental illness requires careful monitoring of psychotropic medications, which have severe and sometimes even life-threatening side effects. The need for substance abuse treatment is much higher among persons with mental illness than in the general population (Drake, Bartels, Teague, Norrdsy, & Clark, 1993; Drake, Osher & Wallach, 1989; Safer, 1987). In addition, the scope of service needs for those with serious mental illness extends well beyond traditional acute mental health services (Drainoni et al., 1993; Lehman, 1987).

Finally, persons with severe physical disabilities are often highly vulnerable to specific health problems, and many experience great difficulty in maintaining good health. For these individuals, a minor health problem can quickly become a major health dilemma (DeJong, Batavia & Griss, 1989; DeJong, Osberg, McGinnis, Seward, Branch & Campion, 1986; Meyers, Felton, Master et al.,1985). In addition, many persons with physical disabilities require an effective personal attendant to enable them to maintain a healthy and independent life (DeJong, 1979; 1981).

Given the range of health and support service they seek, it is clear that providing accessible and effective health care and related services to these three groups of persons with disabilities can be a challenging proposition which has enormous consequences for their well-being. Scientific assessments of the impact of managed care approaches in meeting the varied needs of these individuals, while containing expenditures, assume heightened importance.

While managed care offers the promise of cost-effective, quality health care, little reliable information is at hand about the extent and effectiveness of Medicaid managed care programs for populations of SSI enrolled persons with disabilities. Evaluation studies of managed care programs for special Medicaid populations have examined service utilization and costs, as is the case for studies about the general Medicaid population. However, the limited research focused on persons with disabilities has also looked at health status outcomes

and consumer satisfaction (Horowitz & Stein, 1990; Lurie, Moscovice, Finch, Christianson & Popkin, 1989; Meyers, Cupples, Lederman et al., 1987), as well as the effects of the availability of managed care on use of traditional community-based programs (Christianson, Lurie, Finch, & Moscovice, 1992).

Researchers have also identified critical programmatic, administrative, financial and ethical issues which require rigorous investigation with respect to the effects of Medicaid managed care approaches with populations of persons having cognitive, developmental, physical and/or mental disabilities (Meyers and Master, 1989; Meyers, 1990; Howard, 1991; Mechanic, 1992; and Ferran, 1992). Major stakeholders (federal and state Medicaid officials/policymakers, managed care plan administrators, service providers and consumer advocates) appear to be reluctant to assume that traditional managed care approaches will adequately address the complex health and social needs of these special populations without serious consequences. Broad areas for future research to assist policy and program development include methodologically rigorous investigations which assess:

1. A range of traditional and/or non-traditional service approaches that can contain costs while promoting favorable health/social short and long-term outcomes for persons with disabilities;

2. Implications for collaborations among existing community-based service systems and mainstream managed care programs;

3. Effects of gatekeeping approaches on access and health/social outcomes with these special populations;

4. Rate structures and payment mechanisms that will provide incentives for pre-paid plans to serve special populations; and

5. State and national data management systems capable of tracking the experiences of managed care programs serving these special populations with respect to such factors as, diagnosis, enrollment selection patterns, service utilization, costs, quality of care, client outcomes, client and provider satisfaction.

The study reported here examines each of these issues through a brief mail survey of all states, case studies of eight states that provide Medicaid managed care programs to working-age persons eligible for SSI, and a survey of health plan administrators who manage capitated plans in the states where they are offered.

2. Methods

This research into Medicaid managed care plans serving clients who receive SSI benefits involved several phases, and utilized both qualitative and quantitative research methods. First, a brief mail survey with telephone follow-up was conducted to determine the number of states that included working age adults in the SSI-disabled Medicaid category in their managed health care programs. Next, site visits were conducted to eight states that serve this population through managed care. Finally, we conducted a survey of administrators of all capitated managed care plans that serve this population. Combining these three phases, and using both qualitative and quantitative methods enabled us to obtain a more complete picture of how individuals with disabilities are served in managed care, from the perspective of both the state Medicaid programs and the managed health care plans.

2.1 Data Collection

Sample Selection

During the Spring of 1992, a brief survey was mailed to the Medicaid Director in all 50 states and the District of Columbia to ascertain whether Medicaid managed care was offered and whether it included individuals in the SSI-disabled category. The Medicaid Director or his or her designee (frequently the senior person in the Department responsible for managed care program development) from each state responded. In 17 states the respondent was the Medicaid Director; in 34 states the respondent was another Medicaid official.

Telephone follow-up inquiries were made to all respondents who indicated they served this population through managed care to determine number and types of managed care programs, number of Medicaid beneficiaries in the state, number of SSI-disabled Medicaid beneficiaries, total number of Medicaid clients enrolled in managed care, number of SSI-disabled adults served in managed care, whether the program included those dually eligible for Medicaid and Medicare benefits, year of managed care program inception, rate and payment structure, basic information about benefit design, and whether enrollment of Medicaid clients was mandatory or voluntary. We also requested copies of program descriptions, marketing materials, rate-setting information, and formal evaluations.

After completing the telephone inquiries, it was determined that 16 states served clients in the SSI disabled category in managed care. The 16 states that offered managed care to this population at the time of our inquiry were Arizona, California, Colorado, Florida, Kansas, Louisiana, Massachusetts, Michigan, New York, New Jersey, New Mexico, South Carolina, Pennsylvania, North Carolina, Maryland, and Utah. Seven states offered only fully or partially capitated managed care plans to this population, five states offered only fee-for-service managed care plans to this population, and five states offered both capitated and fee-for-service plans.

Site Visits

Site visits were conducted to eight states. To choose the eight states for the site visit sample, we defined a limited set of criteria for purposive site selection. Site visit states were chosen to provide variation on six selection criteria: geographic distribution, plan type, payment structure, size of Medicaid population, size of SSI-disabled population and proportion included in managed care, and enrollment type. Table A displays each of these selection criteria for the 16 states serving the SSI-disabled population in managed care, based on data provided by each state during the spring of 1992.

Based on the characteristics displayed in these tables, we chose to conduct site visits in California, Florida, Kansas, Colorado, Maryland, North Carolina, Michigan, and Utah. These states represent an urban/rural mix and a range of HCFA regions, as well as variation on our selection criteria. California, Florida, Colorado, Maryland and Utah all have at least 80 percent of their total population residing in urban areas, while Kansas, North Carolina and Michigan each have substantial rural populations. States visited also varied by plan type and payment structure. Florida operated only fully capitated HMOs, while Kansas and North Carolina operated only fee-for-service primary care case management programs. Colorado, Michigan, Maryland and Utah offered both these options to Medicaid clients, while California's primary care case management program was partially capitated. California, Michigan and Utah also offered special managed care programs for Medicaid beneficiaries residing in certain geographic areas. Although states also differed in enrollment type, there was wide variation in the proportion of the SSI-disabled population included in managed care in the mandatory enrollment states, ranging from less than 5 percent in Florida to over half in Kansas and Utah. The selection criteria for the eight site visit states is illustrated in Table B.

Table A: Selection Criteria for States Serving the SSI-Disabled Population

Selection Criteria	Arizona	California	Colorado	Florida	Kansas	Louisiana	Maryland	Massachusetts
HCFA Region		IX - San Francisco	VIII - Denver	IV - Atlanta	VII - Kansas City	VI - Dallas	III - Philadelphia	I - Boston
% Metropolitan/ Non-Metropolitan	87.5/12.5	92.6/7.4	82.4/17.6	84.8/15.2	69.1/30.9	68.1/31.9	81.3/18.7	84.3/15.7
Plan Type	HMO LTC	HMO PCCM COHS	HMO PCCM	HMO	PCCM	PCCM	HMO PCCM	HMO PCCM
Payment Structure	HMO - full capitation LTC - full capitation	HMO - full capitation PCCM - partial capitation COHS - full capitation	HMO - full capitation PCCM - fee for service with case managemen t fee	full capitation	fee for service with case management fee	fee for service with case managemen' fee	HMO - full capitation PCCM - fee for service with case management fee for some programs	HMO - full capitation PCCM -fee for service with enhanced primary care payment
Enrollment Type	mandatory	COHS - mandatory HMO - voluntary PCCM - voluntary	mandatory	voluntary	mandatory	voluntary until July 1992	mandatory	mandatory
# Medicaid Recipients in State	374,854	4,700,000	222,927	1,131,930	168,000	582,522	442,389	575,317
# SSI Disabled Medicaid Recipients in State	42,330	565,084	42,254	244,748	17,300	141,437	49,390	80,310
# SSI Disabled in Managed Care	37,066	18,100	16,833	11,484	8,700	unknown	unknown	54,209

Table A, continued

Selection Criteria	Michigan	New Jersey	New Mexico	New York	North Carolina	Pennsylvania	South Carolina	Utah
HCFA Region	V - Chicago	II - New York	VI - Dallas	II - New York	IV - Atlanta	III - Philadelphia	IV - Atlanta	VIII - Denver
% Metropolitan/ Non -Metropolitan	70.5/29.5	89.4/10.6	73.0/27.0	84.3/15.7	50.4/49.6	68.9/31.1	54.6/45.4	87.0/13.0
Plan Type	HMO PCCM Clinic	HMO	PCCM	HMO	PCCM	HMO HIO CHC	CMHC	HMO PCCM CMHC
Payment Structure	HMO - full capitation PCCM - fee for service with case management fee Clinic - partial capitation	full capitation	fee for service with case management fee	one HMO fully capitated; one HMO partially capitated	fee for service with case management fee	HMO - full capitation HIO - full capitation CHC - partial capitation	partial capitation	HMO - full capitation PCCM - fee for service CMHC - full capitation
Enrollment Type	voluntary until October 1992	voluntary	mandatory	voluntary	mandatory	both voluntary and mandatory programs	mandatory	mandatory
# Medicaid Recipients in State	1,000,000	600,000	180,000	2,000,000	600,000	1,405,370	375,000	95,000
# SSI Disabled Medicaid Recipients in State	148,248	177,000	25,000	182,871	80,400	173,123	62,200	12,065 (ATD)
# SSI Disabled in Managed Care	20,000	780	9,629	unknown	unknown	unknown	216	6,250

Table B: States Selected for Site Visits on Medicaid Managed Care Programs for the SSI-Disabled Population

	Plan Type	Payment Structure	Size of Medicaid Population	Size of SSI Disabled Population	Proportion of SSI Disabled Population Included in Managed Care	Enrollment Type	% Urban/ % Rural	HCFA Region
California	HMO PCCM COHS	Full and Partial capitation	4,700,000	565,084	3.2%	voluntary and mandatory	93%/ 7%	IX - San Francisco
Florida	HMO	Full capitation	1,131,930	244,748	4.7%	mandatory	85%/ 15%	IV -Atlanta
Kansas	PCCM	Fee for service	168,000	17,300	50.3%	mandatory	69%/ 31%	VII - Kansas City
Colorado	HMO PCCM	Full capitation	222,927	42,254	39.8%	mandatory	82%/ 18%	VIII - Denver
Maryland	HMO PCCM	Full capitation and Fee for service	442,389	49,390	unknown	mandatory	81%/ 19%	III -Philadelphia
North Carolina	PCCM	Fee for service	600,000	80,400	unknown	mandatory	50%/ 50%	IV - Atlanta
Michigan	HMO PCCM Clinic	Full and Partial capitation and Fee for service	1,000,000	148,248	13.5%	voluntary	70%/ 30%	V - Chicago
Utah	HMO PCCM CMHC	Full capitation and Fee for service	95,000	12,065 (ATD)	51.8%	mandatory	87%/ 13%	VIII - Denver

To arrange for site visits, a letter was sent to the Medicaid Director of each state, requesting his or her participation. Each Medicaid Director approached agreed to take part in the study and designated a senior staff member to arrange the site visit and coordinate interviews. Site visits took place between September 1992 and January 1993. All interviews were conducted by two Brandeis University researchers to improve the accuracy of recording and verification of results. In order to increase reliability of results, a structured protocol was developed to guide the interviews. Protocol questions were organized in the following nine general categories:

- History of Medicaid managed care program
- Characteristics of population
- Program status and design
- Utilization control and case management
- Data control and analysis
- Financial aspects of managed care program
- Marketing, enrollment and recruitment
- Quality of care
- Current and future status of the program

A copy of the interview protocol is included in the Appendix of this report. Before conducting the interviews, a copy of the protocol was sent to the person in each state organizing the site visit for review and distribution. The following representatives were interviewed in each state: the state Medicaid Director; senior staff from the Medicaid department, including persons responsible for managed care program development, rate setting, quality assurance, and policy analysis. Other interviewees were chosen as necessary and appropriate to the state. The individuals interviewed in each state are identified in the case studies appended to this report.

In addition to the interview results, additional written documentation about the Medicaid managed care program was gathered in each state. This documentation included samples of contracts, program descriptions, marketing and recruitment materials, rate-setting information, program evaluations, and planning documents. The written materials reviewed are identified in the appended case studies. The site visit data include results of both interviews and information from these written materials.

Plan Administrator Survey

The Plan Administrator Survey was conducted for fully or partially capitated managed care plans. To complete the Plan Administrator Survey, we requested a list of capitated managed care plans serving the SSI-disabled population from the managed care contact person in each of the 12 states that offered capitated managed care in 1992. Based on this inquiry, we identified 118 capitated plans in 12 states. After obtaining this list, we contacted each plan to determine the name of the Health Plan Administrator.

The Managed Care Plan Administrator Survey, a telephone survey developed at the Institute for Health Policy at Brandeis University, was mailed to the identified administrators of the 118 managed care plans in February 1993. The survey was divided into five sections to collect the following data:

- Organization of the plan
- Demographics and client satisfaction
- Marketing and service delivery
- Financial structure and data reporting capabilities
- Information about the survey respondent

A letter explaining the purpose of the study was included with the questionnaire as well as the telephone number of the SSI Survey Assistance Hotline at Brandeis, which respondents could call collect if they had any questions. This letter also instructed the plan administrator not to complete and return the survey, but that they would be contacted to schedule a telephone survey time. Interviewees were informed that the survey would take approximately 45 minutes to complete. A copy of the survey and letter is appended to this report.

Approximately two weeks after the surveys were sent, each plan administrator was telephoned to determine whether the survey was received and to schedule a time to complete the survey by telephone. Of the 118 managed care plan administrators sent surveys, seven informed us that the survey did not apply to them, either because their plan served only children or they had never served individuals in the SSI-disabled Medicaid category. Of the 111 plan administrators that reported serving working age adults in the SSI disabled category, 86 completed the telephone interview between March 1993 and May 1993. Data analysis showed that 6 of the plans were no longer serving people in the SSI disabled category, leading to an analyzable data set of 80 completed surveys and a response rate of 76 percent.

2.2 Data Analysis

Site Visit Analysis

Site visit data were analyzed using qualitative research methods. Conceptual categories were created from site visit notes and written documentation. Based on these categories, a case study was written, highlighting the results of our interviews in each state. Drafts of each case study were sent to the state for review. Comments and revisions were incorporated into the final case study reports. The conceptual categories used in the qualitative analysis and case study reports were as follows:

- General characteristics of Medicaid managed care plans serving individuals in the SSI-disabled category
- Program development

- Provider recruitment and participation
- Enrollee recruitment and participation
- Reimbursement
- Quality of care
- Utilization control and data
- Critical issues in Medicaid managed care:
  - Developing integrated plans or carve out plans for persons with disabilities
  - Reimbursement and financing
  - Provider recruitment
  - Mandatory versus voluntary enrollment in managed care
- Defining managed care
- Lessons for other states

Survey Analysis

Data from the Plan Administrator Survey were analyzed using the SPSS-X statistical analysis package on the Brandeis mainframe computer. Analysis was completed on 80 surveys. Univariate analysis was first carried out by computing the frequency of responses in each category. Responses were also cross-tabulated by mandatory and voluntary enrollment, years of experience serving the SSI disabled population, type of plan ownership, plan type, state, and tax status. Statistically significant differences were noted. In addition, multivariate analysis was conducted to identify the effects of a number of significant independent variables on future plans of managed care organizations. The results of the survey assessment and the site visit data are used to support recommendations for states and Medicaid managed care plans on improving the delivery of Medicaid managed care for individuals in the SSI-disabled category.

3. Case Study Results

3.1 Introduction

Both qualitative and quantitative data were examined to further our understanding of the issues involved in enrolling and managing the care of the SSI-disabled population in Medicaid managed care plans. In this chapter of the final report, a summary and analysis of the data gathered during eight state site visits is presented. States selected for site visits included: California, Colorado, Florida, Kansas, Maryland, Michigan, North Carolina and Utah. The methods used to conduct these site visits were described earlier in the report.

Several topics will be addressed in this chapter. First, a general overview of Medicaid managed care in the case study states will be provided. A brief history of the development of these plans will also be given. In addition, critical aspects of enrollee and provider recruitment and participation will be discussed. Following these descriptions, provider reimbursement, quality of care and utilization control practices will be examined. Critical issues in further managed care development for the SSI-disabled population and lessons for other states will also be presented.

3.2 Overview of Medicaid Managed Care Plans for the SSI-Disabled

The eight states that were the subjects of the case studies approached Medicaid managed care plan development in a variety of ways. In some states, such as Michigan and California, both AFDC and SSI-disabled Medicaid recipients had already been enrolled in managed care plans for a number of years. In other instances, such as North Carolina, Medicaid recipient managed care enrollment, even for the lower-risk AFDC population, was a relatively new phenomenon. In some states, such as Kansas and Colorado, Medicaid managed care plans for persons with disabilities were identical to those offered to the AFDC population. In other cases, such as Maryland's Diabetes Care Plan, states developed special managed care programs specifically for persons with disabilities. And in at least one state, clients may be enrolled in more than one managed care plan. In Utah, AFDC and SSI Medicaid beneficiaries could receive their mental health care through the state's mental health managed care program, and their physical health care through another managed care plan.

The eight case study states differed in several general respects, including: (1) the types of Medicaid managed care programs offered, (2) the number of managed care plans participating in capitated programs and the number of primary care providers participating in fee-for-service plans, (3) the percent of SSI-disabled recipients enrolled in managed care plans in each state, and (4) the range of services provided to SSI-disabled Medicaid beneficiaries in managed care. First, the types of Medicaid managed care plans available to SSI-disabled beneficiaries in the eight case study states varied, with a single state often offering more than one type of program. Six states offered nine fully capitated programs, including eight comprehensive health programs and one mental health program. Two of

these, in California, were Health Insuring Organizations, which serve as an administrative services umbrella for managed care providers. These plans are County Organized Health Systems (COHS) and serve all persons residing in a particular county. In fully capitated models, providers receive a prepaid fee each month to provide services to the SSI-disabled population. Only Kansas and North Carolina offered no fully capitated programs for the SSI-disabled.

In addition, seven fee-for-service Primary Care Case Management (PCCM) programs that included the SSI-disabled were distributed among six states. Most of these fee-for-service PCCMs provided health services to the general Medicaid population, but one PCCM enrolled only persons with diabetes. California and Florida had no fee-for-service PCCM programs available to the SSI-disabled population. Two states, California and Michigan also offered partially capitated PCCM programs to SSI-disabled Medicaid beneficiaries. In all, five out of the eight case study states had more than one type of Medicaid managed care program available to this population.

Second, the number of plans participating in capitated programs and the number of providers in fee-for-service PCCM plans also differed by state. For example, Florida had the largest number of fully capitated managed care plans, at 13, while California operated 10, Michigan offered 7, Maryland offered 3, Utah offered 2 and Colorado only one. As stated earlier, Kansas and North Carolina had no fully capitated programs for SSI-disabled Medicaid beneficiaries. And of the six states operating fee-for-service PCCM programs that included this population, Colorado had the largest number of primary care case managers, at 1951, while Michigan had 1849, Maryland had 1500, Utah had 931, North Carolina had 626, and Kansas had 371 providers. California and Michigan, the two case study states offering partially capitated programs, had 18 and 4 partially capitated plans, respectively.

Third, as shown in Table A, there is a range in the number of SSI-disabled recipients enrolled in Medicaid managed care plans, from a low of four percent in Florida, to a high of 76 percent in Maryland. States with larger AFDC enrollment also tended to enroll larger numbers of SSI-disabled recipients in managed care plans. Issues involved in enrolling SSI-disabled recipients in managed care plans will be discussed more fully below.

Fourth, a range of services is provided to SSI-disabled recipients through managed care plans, as shown in Table B. Although a few programs specifically targeted services for SSI-disabled recipients, most Medicaid managed care plans that enrolled the SSI-disabled population provided services that were typically reimbursed by state Medicaid programs, including inpatient, outpatient, lab, pharmacy and certain therapies. California, Colorado and North Carolina provided at least some nursing home coverage, and nursing home coverage was optional in Florida managed care plans. In the other states, nursing home residents were exempt from managed care enrollment. Coverage of psychiatric services also varied from state to state.

3.3 Development of Medicaid Managed Care Plans for the SSI-Disabled Population

All of the case study states had been enrolling Medicaid recipients in managed care plans for more than five years. Michigan was the first state to begin enrolling Medicaid recipients in HMOs, in 1972. North Carolina had the most recently developed HMO program, which began enrolling AFDC recipients in a fully capitated plan in 1986. A majority of the case study states planned to enroll all Medicaid recipients in managed care plans over time. State objectives in enrolling the SSI-disabled population were to improve access to and quality of care, as well as to contain program costs. For the SSI-disabled population, improving recipient access to services was a primary objective of the states.

All case study states operated their Medicaid managed care programs under the authority of a federal 1915(b) waiver of freedom of choice, although California and Florida previously had 1115 demonstration waivers. Many states also operated 2176 Home and Community Based Services (HCBS) waiver programs that may have provided services to some SSI-disabled recipients. Persons receiving services under the 2176 waiver were not typically enrolled in a Medicaid managed care plan.

Most case study states began their Medicaid managed care programs by contracting with fully capitated HMOs. States began to develop PCCM programs after it became apparent that fully capitated HMOs would not provide the market penetration necessary to result in significant enrollment of Medicaid recipients, particularly the SSI-disabled population, in managed care plans. The exception to this trend was Kansas; state officials there determined that contracts with capitated plans for Medicaid recipients would not be possible, given the slow development of capitated plans in the state. Kansas, therefore, began managed care for Medicaid by enrolling recipients in the Primary Care Network, a Primary Care Case Management program modeled after Michigan's Primary Sponsor Plan.

The origins of managed care development varied among the states. For example, Florida began its managed care programs as a site in the federally supported "Competition Demonstrations." North Carolina received support from a private foundation to develop Carolina ACCESS, the state's PCCM program. PCCM programs in California began as the state tried to recover from early troubles with capitated plans, when HMOs used scandalous marketing practices to encourage Medicaid recipient enrollment. However, in general, states began Medicaid managed care development by contracting with HMOs, in the hopes that large numbers of Medicaid recipients would be enrolled in these capitated plans. When enrollment in the plans obviously was limited, primarily because these private plans wanted to limit their financial risk, states began to look for other managed care options that would meet their objectives of managing costs, access and quality of care. PCCM options were developed soon after.

As described previously, investigators inquired about the role of advocacy groups in influencing the development of Medicaid managed care plans for persons with disabilities. In three states, Utah, North Carolina and Michigan, interviewees suggested advocates for

persons with disabilities were hopeful that Medicaid managed care plans for the SSI-disabled population would increase access to health services. In the other states, Medicaid officials had encountered at least some concerns from advocacy groups about how managed care might negatively impact persons with disabilities. However, most advocacy groups directed their concerns not to Medicaid but to another state department whose activities were devoted to the population in question, such as the Department of Mental Retardation, or Department of Mental Health. In one state, Colorado, an Independent Living Center with a strong advocacy focus won the right through the courts to provide HCBS waiver services to a person with mental illness. Although informants were concerned about the impact this case will have on the future provision of HCBS, Colorado Medicaid staff had had few complaints from disability advocacy groups specifically about managed care.

3.4 Provider Recruitment and Participation

The types of physicians eligible to participate in Medicaid managed care varied from state to state. For example, in Colorado, a physician of any specialty could become a primary care provider, while in Florida and Kansas, only physicians with primary care specializations such as internal medicine or pediatrics could serve as a case manager. Providers of long-term care services such as nursing homes were often excluded from managed care program participation.

Seven of the eight states included in the case study sample directly recruited managed care providers. Kansas, however, delegated this responsibility to the program intermediary, Electronic Data Systems, Inc. (EDS), which employed provider relations staff. Although states attempted to increase participation of HMOs, most recruitment efforts focused on primary care physicians. California was the exception to this rule and is discussed further below. A variety of methods were used to recruit primary care providers, including mass mailings, telephone calls and personal visits. Some states reported little difficulty recruiting providers, while others described difficulty recruiting specialists or providers in rural areas. North Carolina had limited expansion of its ACCESS program to areas in which adequate numbers of physicians could be recruited prior to recipient enrollment. In this way, recipients would not bear the negative effects of low provider recruitment rates.

Recruitment of HMOs was hampered by the financial risk involved in enrolling the SSI-Disabled population. For example, some HMOs in Florida had ended their contracts with the state as a result of high cost cases. Medicaid staff in Michigan also reported that capitation rates limited the participation of HMOs. However, California planned to increase recruitment of HMOs and hoped to offer AFDC Medicaid beneficiaries only two fully capitated options, the COHS or an HMO. Persons with disabilities in California would not be required to enroll in the HMOs until a later time, after the plans were well-established.

Primary Care Case Managers were also interested in limiting the risk associated with serving the Medicaid population. For example, providers in Kansas could use an "X" status to indicate they had reached the limit on the size of their desired enrollee population, once

they enrolled the minimum of 50 recipients. Well over half of the physicians participating in the program had an "X" status, indicating they would accept no new enrollees. Physicians could also set their own enrollment limits in Colorado, Utah and North Carolina.

Providers expressed concerns about their ability to manage the care received by program enrollees. Providers suggested they were not always consulted to authorize utilization of the emergency room. Recipients continued to inappropriately utilize emergency facilities since emergency room providers might not call the case manager for approval before providing services. Providers also indicated their concern about the availability of a network to which they could refer care enrollees for specialty services. Finally, providers, particularly those in rural areas, were concerned about their ability to provide 24-hour services to program enrollees.

Many of the concerns primary care physicians had with Medicaid managed care, however, were actually concerns resulting from general frustrations with the Medicaid program. Issues cited by providers included low reimbursement rates, excessive paperwork and poor program administration. ACCESS program staff in North Carolina had actually taken the step of visiting physician offices to help them submit back-logged claims for their regular Medicaid recipients in order to encourage physician participation in the managed care program. Colorado worked closely with provider organizations to encourage physician participation.

3.5 Enrollee Recruitment and Participation

The SSI-disabled population was required to enroll in managed care plans in some or all parts of California, Colorado, Kansas, Michigan, North Carolina, Utah and Maryland. In Florida, participation by the SSI-disabled population in Medicaid managed care plans was voluntary. In states that required enrollment in managed care, recipients were often allowed to choose from several provider options. If a recipient did not choose a managed care provider, the recipient would be assigned a primary care physician. For example, legislation passed in Colorado in 1992 required beneficiaries to be assigned to a primary care provider if they did not select one. In Kansas, however, recipients and managed care providers were not always well matched. For example, interviewees suggested that in managed care counties, at least half of SSI-disabled recipients were enrolled in managed care, but had not been assigned to a primary care physician, since many providers utilized the "X" status to control the size of their enrolled population. These clients thus did not have access to a primary care physician although they were ostensibly in managed care.

Each of the case study states excluded certain recipient sub-populations from enrolling in Medicaid managed care; and several also excluded SSI-disabled recipients from managed care on a case by case basis. Individuals who were dually eligible for benefits through Medicare as well as Medicaid were often excluded from Medicaid managed care because Medicare eligibility limited the states' ability to choose a provider for a patient. For example, California excluded recipients who had had an organ transplant or had end-stage

renal disease. A majority of the states excluded individuals residing in nursing homes or other long-term care facilities such as state mental health institutions. In most cases, these individuals would have been dually eligible for Medicare as well as Medicaid.

In states with mandatory enrollment programs, including Colorado, Maryland, Kansas, North Carolina and Utah, recipients were asked to choose among health plans at the time they applied for Medicaid benefits in local welfare offices. In California, Florida and Michigan, recipients received information about managed care plans from a variety of sources, including door-to-door marketing, presentations in physician waiting rooms, informational mailings, telephone contact, as well as presentations at health fairs and local welfare offices. In these states, the plans were responsible for marketing activities.

Interviewees in California and Florida suggested that managed care providers in these states encountered many more AFDC recipients, and thus were more likely to enroll this population. Plans were also likely to target AFDC recipients for enrollment rather than the more risky SSI-disabled population. However, interviewees also suggested that SSI-disabled recipients may be less likely to enroll in a managed care plan because they already had their own provider and may therefore be less likely to want to establish a relationship with a new provider.

All states but Kansas planned to increase Medicaid managed care enrollment for the general Medicaid population and thus for the SSI-disabled population. Informants in Kansas suggested they had had limited success in rural areas, and were still unclear about whether the program was effective. These issues, in addition to the problems the state had in contracting with primary care providers, influenced state policymakers to limit managed care development to the counties that were currently participating in the program. In the remaining states, policymakers intended to expand Medicaid managed care enrollment to the greatest extent possible, in some cases to the entire Medicaid recipient population.

3.6 Reimbursement

Most states used a variety of reimbursement models in their Medicaid managed care plans. However, two of the case study states, Kansas and North Carolina, utilized only the PCCM model for their SSI-disabled population. Kansas had no other Medicaid managed care models, while North Carolina contracted with a Kaiser HMO to provide services only to the AFDC population. In both Kansas and North Carolina, PCCMs received a monthly case management fee to manage the services provided to program enrollees. Kansas case managers received $2 each month per enrollee, while North Carolina case managers received $3 for the first 250 enrollees, and $2.50 for enrollees beyond that limit. Kansas physicians were reimbursed using fee-for-service methods according to usual and customary Medicaid rates, while North Carolina physicians were reimbursed at 90% of Medicare's resource based relative value scale (RBRVS) rates.

The remaining states all offered both fully capitated HMOs as well as PCCMs to their Medicaid population. At the time of the site visits, Florida had not yet expanded its PCCM program to include the SSI-disabled population, although, as noted above, this expansion was planned. In addition to HMO and PCCM models, California, Michigan and Utah all offered other types of managed care models to the SSI-disabled population. In California, two counties, Santa Barbara and San Mateo operated fully capitated county based managed care programs for the SSI-disabled population. In addition, all of California's PCCMs operated on a partial capitation model. Michigan also offered four partially capitated managed care organizations that were specific to the state, called Clinic Plans. Clinic Plans were based in physician practices, and at the time of the site visits, did not meet state requirements for licensure as managed care providers. The state was in the process of working with these organizations so they would conform to state requirements for PCCMs. Finally, Utah operated a mental health HMO, in which all Medicaid recipients in participating counties were enrolled. Recipients were required to use the HMO for any mental health services.

Most states had developed capitation rates for the HMOs that were adjusted according to client age, gender and eligibility category. Based on experience covering persons with disabilities, capitation rates for the SSI-disabled category were three to four times higher than rates for the AFDC population. States sometimes provided reinsurance, or mandated that capitated plans provide their own reinsurance, but not in all cases.

The PCCM models used in the case study states typically relied on fee-for-service reimbursement, with services provided to the SSI-disabled population managed by a case manager. Often, the case manager was reimbursed a small fee for managing care. However, in Utah, the state had ceased to provide the case management fee, on the grounds that the small fee was not an adequate incentive to change physician behavior, and was also difficult to administer. And in Maryland the case management fee was offered to Diabetes Care program providers only. In general, fee-for-service PCCMS were under no financial risk. However, providers in California and Michigan's partially capitated programs participated in a shared savings model, in which any savings resulting from managed care were shared between the provider and the state. In all the case study states, Medicaid recipients were not often asked to share in financial risk through co-pays, deductibles or savings.

3.7 Quality of Care

Case study states monitored quality of care delivered in Medicaid managed care plans using methods states have traditionally used to assure quality in all their programs. For example, managed care providers were required to be licensed in the state, and typically underwent the same inspection, audit and monitoring procedures that were used for other Medicaid providers.

States also developed other procedures to monitor the quality of care delivered in managed care plans. Most states, for example, had conducted patient satisfaction surveys of

managed care enrollees. Kansas and Colorado had also conducted surveys of managed care providers. All states required managed care providers to have an enrollee grievance system; staff in all states then followed-up on enrollee grievances. Some states, such as North Carolina and Utah, were developing quality assurance plans and standards of care for services provided by managed care plans.

A review of disenrollment trends is often included in state quality assurance programs. Informants in California and Florida said these states conducted disenrollment or member satisfaction surveys, while North Carolina managed care staff conducted a case by case review of disenrollees. Recipients disenrolled from managed care plans for the following reasons: loss of Medicaid eligibility, general dissatisfaction, misunderstanding of benefits, or a desire to return to a previous provider. Prior to the development of the mental health capitated plan in Utah, clients were disenrolling from managed care plans to access mental health benefits. In states where managed care is mandatory, disenrollment from managed care is not possible since clients must enroll in a health plan; choice to change plans is periodically given, however.

All states suggested that the quality of care delivered in managed care plans met or exceeded state expectations. Disenrollment from managed care plans was low, as enrollment was often mandatory, or SSI-disabled recipients may have had difficulty accessing other providers. Occasional examples of enrollee grievances were given, but for the most part, key informants suggested that the quality of care provided to SSI-disabled recipients through managed care plans was more than adequate.

3.8 Utilization Control and Data

The case study states used a variety of mechanisms to control and manage recipient utilization of services, including: case managers, PRO review, SURS data reports, second opinion programs, recipient co-pays, recipient lock-in programs, as well as a variety of other state-specific methods. All states had established a prior approval program in which managed care enrollees were required to seek approval from the managed care organization before receiving non-emergency services. Prior approval usually was given by the enrollee's case manager, typically the primary care physician.

Many managed care plan utilization control activities were focused on managing use of hospital emergency rooms. Program managers were trying to encourage recipients to access services through their case manager rather than by attempting to first seek care from emergency rooms. Informants gave mixed responses about their ability to control emergency room utilization. For example, in California, interviewees suggested that there has been a decrease in emergency room utilization, but were not sure if this decrease should be attributed to case managers, program efficiencies, lack of service availability, or the type of clients that enrolled in the managed care programs. Informants in Colorado, Kansas and Utah all expressed concerns about the effectiveness of utilization control programs, citing the use of emergency rooms as a key area of concern.

State officials are not as involved in utilization control activities for fully capitated programs as they are for PCCMs. For example, informants in Florida, Maryland, Michigan and Colorado suggested they relied on HMOs to manage recipient utilization, and did not receive data about utilization review activities within the HMO. None of the case study states gathered person specific data from their fully capitated plans. These plans typically provided states with monthly, or quarterly aggregate information about services provided and the cost of those services. Moreover, none of the case study states had examined utilization and cost data for different sub-groups of the SSI-disabled population, including utilization of health services by type of disability. And, few states had compared utilization and cost data for the SSI-disabled population in managed care to that of their counterparts in the regular Medicaid program. In some states, including Colorado, Florida and Kansas, state policy makers reviewed utilization of services by physician case managers to identify physician outliers. And, in Michigan, Utah, and California, methods were developed to gather data from specific managed care programs, such as the capitated county health program in Santa Barbara. Special reviews were conducted of high utilizers in the SSI-disabled population in Michigan, California and Maryland.

In general, states wanted more information about the SSI-disabled population and their use of health services. Interviewees in California noted they were working on a minimum data set for this population, as well as other managed care enrollees. The state planned to include outcome information in this data set. Utah also had begun to develop pseudo-claims for services provided in the capitated mental health program.

3.9 Critical Issues

Results of interviews conducted in eight of the 16 states that enroll the SSI-disabled population in Medicaid managed care plans indicate states promoted enrollment in these plans for consistent reasons: to manage access to services, quality of care, and cost-effectiveness of services for persons with disabilities. Officials indicated that they confronted several critical issues in developing managed care plans that include persons with disabilities. Reimbursement issues were paramount. States were exploring a range of models for reimbursing managed care providers, including full and partial capitation models, as well as fee-for-service models with and without case management fees. More states planned to expand enrollment in the fee-for-service PCCM model. Growth of fully capitated options was hampered by lack of provider interest and the question of how to distribute financial risk among the providers, the plan, the state and the recipients. However, states were not clear that fee-for-service PCCM models were resulting in any efficiencies of service delivery. Their experience suggested that recipients continued to access emergency rooms without prior approval of the case manager. The results of our interviews do not suggest that one managed care reimbursement model was preferred over another for the SSI-disabled population. The choice of reimbursement model seemed to be situational, depending on the provider community and the culture of the state.

Second, in addition to variation in reimbursement models, states have exhibited variety in terms of the services, populations, and geographic regions that are included in Medicaid managed care plans for the SSI-disabled population. For example, Utah developed a capitated plan only for mental health services. California had two county operated health systems that provided capitated services only to residents of these counties. Maryland's HMOs were available only in certain densely populated counties. States have thus drawn the boundaries around managed care for persons with disabilities in a variety of ways. States continue to face a challenge in deciding whether to carve out specific services or populations, particularly for higher risk persons with disabilities, or to develop integrated programs that include all Medicaid eligible populations and services.

Third, growth in Medicaid managed care plans for the SSI-disabled as well as for other eligibility groups was hampered by general provider dissatisfaction with the Medicaid program. Interviewees cited low reimbursement rates, administrative hassles and non-compliant clients as problems with the Medicaid program in general that were extended to provider attitudes about Medicaid managed care for the SSI-disabled population. Providers were reluctant to become more involved with the Medicaid program, and thus were hesitant to become managed care providers. Provider recruitment in general was a difficult problem for most states that are trying to expand their Medicaid managed care programs.

Fourth, few evaluations had been conducted on existing managed care models to determine whether these programs in fact increase access to services, and contain costs for the SSI-disabled population. It was unclear whether the managed care programs in operation were providing adequate coverage of health related services more likely to be needed by individuals with disabilities, such as supportive services. Without systematic information about the specific impact of managed care programs on this population, the states' planning for this group was somewhat limited. Interviewees indicated that better tracking of program impacts depended on the development of improved data systems. However, although states currently know little about their SSI-disabled Medicaid beneficiaries in managed care programs, interviewees were interested in learning more about this population and how they may improve managed care services to these Medicaid consumers.

Finally, states had to decide whether to make enrollment in Medicaid managed care plans voluntary or mandatory for recipients. Some states, such as California, planned to expand managed care enrollment on a mandatory basis to all areas and all recipient categories, although they intended to enroll persons with disabilities after other groups have been incorporated. Other states, such as Kansas indicated they would not make Medicaid managed care a state-wide mandatory program because they had no clear evidence of positive outcomes.

These critical issues were the major decision points that state policymakers faced in designing and expanding Medicaid managed care plans for the SSI-disabled population. Decisions about reimbursement models, services to be included, and populations to be served were likely to be made based on relationships state policymakers have with providers in the state, the efficiency of the Medicaid program, and the extent of general managed care growth in the state.

4. Health Plan Administrator Survey Results

4.1 Introduction

The results of the Health Plan Administrator Survey are discussed in this section. Administrators in capitated health plans described their experiences in providing Medicaid managed care services to SSI-disabled adults and assessed how well managed care worked to serve persons with disabilities. Results reported upon include plan organization, SSI-disabled client characteristics, aspects of service delivery, financial structure, and data reporting capabilities of managed care plans. Administrators' perceptions are also analyzed regarding access to care for SSI-disabled adults, utilization of services of SSI clients compared to other Medicaid beneficiaries, the benefits of providing capitated managed care to the adult SSI-disabled population, and the costs.

A total of 4.2 million working-age adults with disabilities received SSI cash benefits in 1993 and were also eligible for Medicaid health care benefits (SSA, Spring 1994). The data reported in the Methods chapter show that less than 5 percent (200,000) were in Medicaid managed care programs in 1992. Thus, the plans have had relatively limited experience in providing managed care to SSI-disabled adults. As this chapter will show, most plan administrators who were surveyed in 1993 thought some aspects of the plan worked well for persons with severe disabilities, most expected to continue the plan as is, but few had person-based data about enrollee age, gender, or type of disability that could be related to any outcome variables such as cost and utilization of services.

Conducting the Survey

Of the 16 states studied, 4 had fee-for-service managed care plans and 12 offered managed care programs with capitated payment rates for working-age adults who received SSI. Medicaid directors from the 12 states with capitated plans were asked to provide a list of fully and partially capitated Medicaid managed care plans and their directors. Health plan administrators were surveyed by telephone from March through May 1993 to collect information about managed care plan organization, client characteristics, and administrator experiences with and attitudes towards providing managed care to persons with severe disabilities. From the original 118 plans listed by the Medicaid directors, 105 plans were found to be providing services to SSI-disabled adults. Of these, 80 plan administrators completed the Health Plan Administrator Survey, for a survey response rate of 76 percent. The SPSS package was used to analyze the data and produce statistical results (See Methods Chapter for a more complete description and Appendix B for a copy of the survey with item responses reported.)

Hypotheses and Indicators

We hypothesized that the perceptions of health plan administrators about how well managed care plans served persons with disabilities would be influenced by 3 factors: (1)

whether Medicaid managed care enrollment for SSI-disabled clients was mandatory or voluntary; (2) if the plan had full or partial capitation; and (3) what type of managed care was in place.

Indicators of the effectiveness of managed care plans were operationalized as administrators' described future plans to serve SSI-disabled adults. To measure the type of choice clients had, plan enrollment was classified as voluntary or mandatory. In some states, both options existed in different areas or for different subpopulations. The degree of plan capitation was measured by whether capitation rates covered the full range of services provided to clients or a partial range. Typically, partially capitated plans covered the majority of outpatient services while fully capitated plans covered both inpatient and outpatient services.

Finally, the type of managed care model was categorized. About 60 percent of the plans could be classified by degree of centralization. HMOs, 27 percent of the plans, were assumed to be more centralized than IPAs, 22 percent of the plans, which were thought to be more centralized than PCCMs, 11 percent of the plans. PCCM respondents to this survey were primarily located in California in partially capitated plans. An additional 14 percent of the plans were CMHCs and were located in South Carolina and Utah. Although CMHCs were primarily responsible for providing mental health care, and not medical care, they were not excluded from further analysis because CMHCs deliver managed care to a growing numbers of individuals with serious mental illness. Among the remaining plans, 26 percent were other types plans or mixed more than one type of organization. In the following analyses, plan type is divided into five categories: HMOs, IPAs, PCCMs, CMHCs, and Other.

In the following sections, univariate and bivariate results will be presented that show how state level, plan level, client level, and administrative level data influenced the delivery of managed care to persons with disabilities.

4.2 The Role of the State

Medicaid managed care plans that served SSI-disabled adults tended to be located in states where enrollment in managed care was voluntary, at least for this population. Moreover, these plans were more likely to be fully capitated and were distributed across diverse managed care models. Table 1 shows the distribution of plans by plan model, SSI-disabled state enrollment type, and plan capitation category. As noted in Table 1, 26 percent of the plans were HMOs, 22 percent were IPAs, 14 percent were CMHCs, 11 percent were PCCMs, and the remainder were mixed or other types of plans. Two thirds of the plans were fully capitated, and more than half were in states with voluntary plan enrollment for the SSI-disabled adult population. These results are statistically significant. Not surprisingly, HMOs, IPAs and CMHCs were fully capitated, while PCCMs and plans in the residual other category were partially capitated. IPAs and CMHCs were more likely to be in states with

mandatory SSI-disabled adult enrollment while HMO and PCCM plans were more likely to be found in states with voluntary enrollment.

The state plays a prominent role influencing access to managed care plans for persons with disabilities. States may require SSI-disabled adults to be automatically enrolled in Medicaid as well as determine whether enrollment in Medicaid managed care plans is mandatory or voluntary. Most states surveyed (10 of the 12) automatically enrolled SSI recipients in Medicaid, and, in those states, Medicaid recipients had ready access to join plans that contract with the State.

The number of people who are eligible for SSI benefits may also be influenced by state policy. Typical plan size across all 12 states was about 28,000 total enrollees with about a third of enrollees having Medicaid as a source of payment. Less than one percent of plan members were SSI enrollees. The role of the state may influence plan organizational characteristics, client characteristics, service utilization and data reporting.

4.3 Plan Organizational Characteristics

Plan organization has a major impact on the provision of services to persons with disabilities who receive SSI benefits. Six elements are assessed here: plan structure, marketing strategies, client characteristics, service array included in capitation rates, utilization of services, and rates of appeals for denied services. Each of these areas is described and selected comparisons are made between state enrollment types, capitation categories, and among plan types.

The Organizational Structure of the Plan

We examined the organizational structure of the plans to identify differences in tax status, ownership, plan size, percent of Medicaid enrollees, percent of SSI enrollees, physician characteristics, and plan configuration. Table 2 results show some statistically significant differences by plan type, enrollment type, and capitation model.

Among the plans studied, more reported voluntary enrollment (54 percent), full capitation (67 percent), and were more likely to be HMOs or IPAs (26 and 22 percent, respectively) than PCCMs (11 percent) or CMHCs (14 percent). In addition, the majority of plans were non profit (65 percent) and privately owned (75 percent). About 10 percent allowed providers to refuse to serve the SSI-disabled population, and more than a third of plans (38 percent) reported that some of their providers saw disproportionate numbers of SSI-disabled clients.

There were statistically significant differences by plan type across all the organizational elements. Enrollment differed statistically by tax status and ownership; and capitation varied by ownership and provider practice patterns. For example, the majority of PCCMs were for profit organizations, whereas HMOs, IPAs, and CMHCs were more likely

to be non-profit. The vast majority of plans were privately owned, except for state owned CMHCs located in the South.

Refusal to serve SSI-disabled clients was significantly less likely to happen in the more centralized plan types than in the more loosely structured ones. No providers refused to serve SSI-disabled clients in HMOs and PCCMs; only 6 percent refused in IPAs. However, about one fifth of providers in CMHCs and other types of plans were allowed to refuse to serve these clients. Furthermore, provider practice patterns, reflecting disproportionate care of clients with disabilities, varied tremendously by plan type. Only about a third of HMOs reported providers who treated most of the practices' disabled patients with SSI; half specialized in IPAs, and more than two thirds of Other plans reported providers that specialized in this population.

Although only a quarter of the plans were state owned, more than a third of these were partially capitated. And, providers were more than twice as likely to treat SSI enrollees in fully capitated than in partially capitated plans. Mandatory or voluntary enrollment also varied significantly by organizational characteristics. For profits were three times as likely to have voluntary enrollment as mandatory enrollment.

Overall, plans that provided services to SSI recipients who had disabilities were mostly large, privately owned non-profits with about 10 years managed care experience and 7 years experience with the SSI-disabled population. Median total plan enrollees was nearly 28,000 individuals, and Medicaid beneficiaries (9,000) represented almost a third of plan enrollees. However, there was limited direct experience treating the SSI-disabled population. On average, less than five percent of Medicaid enrollees (415 of 9,000) were in the SSI-disabled enrollment category. The median number of physicians who worked in these plans was 175.

Plan size varied by enrollment, capitation and plan type. IPAs typically reported larger median enrollment figures (49,500) than any other plan type; whereas PCCMs indicated having relatively small enrollments (8,050). Similarly, IPAs reported more Medicaid enrollees in their plans but these represented about 29 percent of plan population as compared to HMOs and Other plans where a third of their population were Medicaid enrollees. All PCCM plan enrollees were Medicaid funded as were the CMHCs. However, in terms of the number of SSI enrollees in the plans, HMOs had twice as much experience as any of the other plan types both in terms of people served (1,036) and years providing managed care service (15.2 years) and specifically service to the SSI recipients (8.9 years). The largest association of physicians was found in the IPAs (1,140), where PCCMs had relatively few physicians (40).

Plans with voluntary enrollment were about twice as large as those with mandatory enrollment (31,387 vs. 14,800) and their Medicaid populations were also larger (9,876 vs. 6,229). Nevertheless, the proportion of SSI-eligible clients in Medicaid managed care plans was higher in mandatory enrollment states. About 7 percent of plan enrollees were SSI-

eligible in mandatory states; about 4 percent were represented in voluntary states (450 in mandatory plans, 404 in voluntary plans).

Plans in mandatory enrollment states were more likely to be non-profit, privately owned, smaller, and have fewer years experience in providing either managed care or managed care to SSI-disabled recipients than those in voluntary states. Furthermore, plans with mandatory enrollment had about half as many physicians but were more likely to allow some physicians to refuse to treat SSI-disabled recipients while others treat a disproportionate number.

Plans in states with voluntary enrollment were more apt to have a for-profit tax status, more private ownership, and to be larger. They had more enrollees in all categories, except, interestingly, SSI-disabled enrollees; more years in managed care; and more physicians than plans in mandatory states. In plans in states with voluntary enrollment, fewer physicians opted out of treating the SSI-disabled population but fewer specialized in treating persons with disabilities.

Fully capitated plans were more likely than partially capitated plans to report non-profit tax status, be privately owned, be about ten times as large as partially capitated plans, and have more experience with managed care. In nearly half of fully capitated plans, some providers saw a disproportionate number of SSI-disabled enrollees. Less than 20 percent of partially capitated plans reported that some providers saw more SSI-disabled clients than others.

Plans' Marketing Strategies

Marketing strategies are displayed in Table 4. Among all plans, the most common marketing techniques were solicitation at the local welfare office (40 percent) and door to door canvasing (26 percent). About 20 percent of plans sent mailings to potential clients or providers to encourage participation in plans.

Plans in voluntary states relied heavily on marketing strategies to attract clients. Establishing contact through the local welfare office was the most frequent marketing strategy, used by 60 percent of these plans as compared to 17 percent of mandatory plans. Forty percent of voluntary enrollment plans used door to door marketing while only 6 percent of plans in mandatory states followed this strategy. These differences are statistically significant.

Not surprisingly, plans in states with mandatory enrollment spent less time marketing managed care to SSI clients than plans with in states with voluntary enrollment. However, states with mandatory enrollment in managed care usually offered clients a choice of managed care plans, providing some incentive for the plans in mandatory states to market their plan. About one in six plans in mandatory states used the mass media to advertise, contacted providers, and contacted clients through the welfare or social security offices.

Nevertheless, plan marketing strategies did not appear to compensate for state mandated enrollment in managed care plans. The extra efforts of the plans in voluntary states did not make up for state mandates in enrollment of the SSI-disabled population.

Marketing strategies, particularly door to door solicitation and contacting providers, also differed by capitation and plan type. Partially capitated plans relied on door to door marketing as compared to fully capitated plans (42 percent vs. 19 percent), but were less likely to contact providers to attract them than were fully capitated plans (27 percent vs. 47 percent). These differences are statistically significant.

In summary, Medicaid clients made up a substantial part of the managed care plans' business, but only a small percent of enrolled clients were in the SSI-disabled category. Plans were relatively well-established in terms of size and years providing managed care. The number of SSI enrollees was higher in plans in mandatory states than in plans in voluntary states, and they were also more likely to be in fully capitated plans compared to partially capitated plans. Plan organizational characteristics differed substantially by plan type, but enrollment and capitation more frequently influenced marketing strategies than did plan type.

4.4 SSI-Disabled Client Characteristics and Utilization of Services

A major goal of this study was to examine demographic characteristics of adults with disabilities who were enrolled in managed care plans. However, few plans routinely gathered demographic information on a per client basis. Although interviewers consistently encouraged respondents to report per enrollee demographic data, only a third of the plans could retrieve information about gender, just 20 percent had discrete age information, and less than 15 percent collected race/ethnicity or type of disability data. In Table 5 data that were available about clients are arrayed first by state enrollment type and plan capitation category and then by type of plan.

Medicaid Enrollment Caps

More than half of the health plan administrators reported caps on the number of Medicaid clients they enrolled. Medicaid caps were reported in nearly two thirds of the plans in voluntary enrollment states, compared to slightly more than one third of the plans in mandatory states. Caps were also much more common in partially capitated plans, 76 percent, compared to fully capitated plans, where less than half (40 percent) indicated caps were in place. These differences are statistically significant. Few plans reported caps on SSI recipients, although caps were twice as likely in partially compared to fully capitated plans. However, Medicaid caps may have already restricted access of the SSI population.

Age of Clients

The majority of plan clients were under the age of 45. However, client populations tended to be older in plans in states with voluntary enrollment compared to mandatory enrollment, and in partially capitated compared to fully capitated plans. Most plans (86 percent) reported enrolling clients who were dually eligible for Medicaid and Medicaid benefits, but this was more likely to be the case in states with voluntary enrollment (93 percent) and in plans with full capitation (92 percent). However, there were no statistically significant differences in client age by enrollment, capitation, or plan type.

Consumer Satisfaction Measures

Nearly all plans (83 percent) said they regularly measured consumer satisfaction. Despite these reports, more than a third of the plans (39 percent) did not know if their disabled clients were satisfied. However, plan administrators' perceptions of SSI client satisfaction were higher in states with voluntary enrollment (65 percent) and in plans with partial capitation (76 percent) plans, compared to their counterparts.

Most plans could not report about the satisfaction of disability groups with the plans' organization. Almost 60 percent did not know what opinions were held by advocacy organizations (See Table 5). There were no statistically significant differences by enrollment, capitation, or plan type.

Concurrent Beneficiaries

Although most plans that responded to the survey (86 percent) reported including clients who received both SSI and SSDI benefits, there were statistically significant differences for concurrent beneficiaries by enrollment, capitation, and plan type. Plans in voluntary states were more likely to enroll concurrent beneficiaries than those in mandatory states (93 percent vs. 77 percent). There was a similar difference for fully and partially capitated plans (92 percent vs. 71 percent). All HMOs, PCCMs, and Other plans (100 percent) enrolled concurrent beneficiaries. Only 36 percent of CMHCs and 77 percent of IPAs reported enrolling clients with concurrent benefits.

It can be seen that capitation and plan type, which are strongly intercorrelated (see Table 1), have a stronger association with client characteristics than does type of state enrollment. Plans in voluntary states were more likely to implement a cap on Medicaid recipients and to enroll concurrent beneficiaries than were those in mandatory states. However, there are more significant relationships by capitation and plan type. Partially capitated plans are significantly more likely to impose caps on Medicaid and SSI recipients, are less likely to enroll concurrent beneficiaries, and reported their clients were more satisfied than fully capitated plans. Caps on Medicaid recipients were universal among the PCCM plans interviewed, whereas only slightly more than a third of IPAs reported such caps. Clients were younger in HMOs and IPAs than in PCCM plans. All HMOs and

PCCMs enrolled concurrent Medicaid and Medicare beneficiaries, but only three quarters of IPAs enrolled these dually eligible clients. HMOs were more likely than IPAs or PCCMs to regularly conduct client satisfaction surveys but still more than half (55 percent) of HMO administrators did not know how satisfied clients with disabilities were with their plan. Similarly, HMO and PCCM administrators (75 percent in each group) were largely unaware of satisfaction levels among organizations that advocate for the disabled.

The Availability of Services

Service availability was estimated by comparing the total number of services offered by the plan to the number of services covered by the plan's capitation rate. A ratio was calculated, which is presented in Table 6. Between half and two thirds of plans included important services in the SSI capitation rate that were also offered to other non-SSI plan members.

- Sixty percent of managed care plans included the following services in their capitation rates: speech therapy, psychiatric hospitalization, prosthetics, occupational therapy, group psychotherapy, intermediate health care, and skilled nursing care.

- Glasses, day treatment, and substance abuse treatment were covered in at least half of the plans.

- However, fewer plans included dental care (38 percent), personal assistance services (30 percent) or respite care (24 percent). Each of these last three services are likely to be important to persons with serious disabilities or their family members.

The range of services included in plan capitation rates clearly varied by plan type. HMOs were most likely to both offer and include the majority of these services, making HMOs attractive for their wide range of services. However, services especially important to families with members with serious disabilities appeared to be more likely to be covered in IPAs than in HMOs. For example, IPAs were more likely than HMOs to cover psychiatric hospitalization (95 percent vs 86 percent), day treatment (53 percent vs 38 percent) or respite care (35 percent vs 29 percent). These types of services provide family members with more flexibility in caring for someone whose impairment may vary in intensity or would allow primary caretakers to have time to either work or attend to other needs than those of the disabled person.

How Difficult Is It to Provide Services for SSI-Disabled Adults?

Health plan administrators were also asked to compare provider attitudes about service utilization of SSI clients to AFDC clients, the majority of plan Medicaid clients. It is interesting to note that over a third of the administrators did not answer these questions. However, about a third of administrators indicated that both physicians and other health care

providers reported no difference in the number of problems encountered in serving persons with disability who receive SSI benefits, compared to AFDC clients.

Service use was reported to vary by population type. Administrators indicated that AFDC clients used more primary care services than SSI clients. In addition, AFDC clients used more family planning, emergency, substance abuse treatment and dental services than SSI clients. However, SSI clients were reported to use more costly and more specialty services, such as hospital inpatient, support services, coordination of non-medical services, psychiatric hospitalization, and outpatient psychotherapy (See Table 7).

Plan administrators reported that few SSI enrollees appealed service denial decisions. However, more than a quarter of administrators did not know how frequently SSI clients appealed plans' denials of service. As Table 8 shows, the majority of administrators were not aware of appeals of decisions about mental health services, procedure location, length of stay or requests for durable medical equipment. Between 21 and 42 percent of administrators reported that they had no experience of SSI clients appealing any of these types of service decisions. In fact, less than 6 percent of administrators said any of these decisions were either very or somewhat frequently appealed.

In summary, utilization of plan services was somewhat restricted by Medicaid caps, particularly in states with voluntary enrollment and among plans with partial capitation. Caps were also likely to exclude SSI recipients. Most plans enrolled concurrent SSI and SSDI beneficiaries, but this was more common in plans in voluntary enrollment states and in plans with full capitation. Four out of five plans said they regularly measured consumer satisfaction, but two out of five plans indicated they had no knowledge of client satisfaction levels among persons with disabilities who received SSI benefits. Administrators also had little information about satisfaction levels among disability advocacy organizations.

Service availability and utilization clearly varied by plan type. HMOs were more likely to include more services in their capitation rates, but IPAs were more likely to cover services needed by persons with serious disabilities, especially mental health services. Administrators had little specific information about SSI client characteristics and service utilization. Many planned analyses could not be carried out because most plans had little per client data to assess the impact of managed health care delivery to persons with disabilities. Data reporting capacity and financial arrangements are discussed in the following section.

4.5 Data Reporting Capacity and Financial Arrangements of Plans

Administrative Data Reporting

Administrators collected data to facilitate administrative reporting rather than provide information about client demographic or medical history. As table 9 shows more than 70 percent of the plans reported they collected service utilization data on a person-specific basis, and two thirds had per person data for AFDC clients and for SSI-disabled adults in general.

However, very few plans were able to identify clients by type of disability. Only 20 percent could identify clients with mental illness, 14 percent could follow clients with a physical disability, and only 11 percent could identify clients with a developmental disability. Data reporting systems were organized for administrative purposes, by payment category, rather than for devising care plans that would include demographic or personal characteristics.

While plans in mandatory enrollment states were more likely to track service utilization on a person-specific basis, they were also less likely than those in voluntary enrollment states to collect detailed demographic client data. Although few plans could report these data by type of disability, among those that did, plans with full capitation reported more specific data than partially capitated plans, and this difference is statistically significant. Although there were differences in reporting by plan type, none of these was statistically significant.

Rate Setting

Among the 77 plans that reported information about rate setting, the majority (57 percent) indicated that capitation rates were usually set by the states; the remaining 43 percent of plans negotiated rates with the state (see Table 10).

Less than half of the plans responded to questions about how rates were differentiated. A third of the plans (25 plans) reported about rates differentiated by gender; 35 plans (44 percent) gave information about rates differentiated by age. This later statistic implies that more than half of the plans were not able to distinguish service utilization between children and adults. Among those plans (20 percent) that did report demographic information, nearly all indicated that rates were differentiated by age, gender, and disability. Where the state uses its own Medicaid service utilization data to determine rates, plans may not feel compelled to collect demographic data. Nevertheless, this information would still be useful to plans for careful managing of plan resources.

Most plans responded to a question about the adequacy of rates. Sixty-five percent said rates were at least adequate for AFDC clients; 62 percent replied similarly for SSI disabled adults. CMHCs were more likely to report adequate rates for SSI disabled adults (100 percent) than were HMOs (55 percent), IPAs (64 percent) , and especially PCCMs (14 percent). These differences across plan type are statistically significant.

Risk sharing takes many forms and most plan administrators responded to this question (72 plans). In more than a third of plans (29 plans), risk was not shared for losses or surpluses due to specialty care costs. Among the remaining 43 plans, risk was shared most widely in CMHCs (91 percent). About two thirds of IPAs and PCCMs (62 percent each) reported sharing risks. However, more than half of HMO providers (52 percent) did not share risk for losses.

Fifty plans reported data about stop loss insurance. Stop-loss limits are reached when a specified total dollar amount has been spent. Stop-loss insurance is typically activated by an individual consumer's record of utilization of services, not by an analysis of client-based episodes of care. Among plans reporting stop loss data, 80 percent reported stop loss insurance was based on an individual consumer's utilization.

4.6 Opinions about Managed Care for SSI-Disabled Population

Health plan administrators were asked about their perceptions of factors that might influence access to, quality of, and costs of managed care for SSI-disabled adults. The specific issues explored include reasons for enrollment of the SSI-disabled population, barriers to enrollment, the role of advocacy groups in fostering managed care plans, administrators' reports of aspects of their managed care plans that were working well for the SSI-disabled population, and future plans for enrolling this group. In the following discussion, these issues are examined through bivariate analysis by plan type, state enrollment type, and/or plan capitation category.

Access to Care

One measure of access to Medicaid managed care plans is the ease with which clients may enroll in a plan. Access for the SSI-disabled population is likely to be influenced by multiple variables at different levels of health care delivery. For example, although state policies may mandate enrollment in managed care plans for all Medicaid recipients, advocacy groups may resist a medical managed care model and local providers may be disinterested in treating a complex population. Thus, access to managed care could be restricted at the system level.

Plan level variables, such as full or partial capitation payment arrangements, the need to increase plan enrollments or a goal of improving organization and delivery services to this population, may also facilitate or impede the ability of persons with disabilities to enroll in Medicaid managed care plans. Client level variables, such as physical or cognitive disabilities, degree of impairment or need for special services, may affect client access. Finally, administrators' experiences in serving persons with disabilities may encourage or discourage staff from promoting enrollment of adults in the SSI-disabled category.

As Table 11 shows, 86 percent of plans enrolled the SSI-disabled population because of state policy mandating that they do so. Even in plans in states with voluntary enrollment, however, a high percentage of plan administrators enrolled adults in the SSI-disabled category to comply with state goals. About half of plan administrators (54 to 58 percent) related they enrolled individuals who received SSI-disability payments to improve coordination of health care services, to manage costs and utilization better, and to better organize referrals to specialists.

Less frequently, plans cited increasing enrollment or requests from families or providers to include the SSI-disabled in the plan About 40 percent of administrators wanted to increase total plan enrollment. Administrators in about a third of plans reported that they enrolled SSI-disabled adults because they or their families, or their health care providers requested access to managed care for this group.

In states with mandatory enrollment, access was open to SSI-disabled adults primarily because of state mandates (91 percent). Health care providers and advocacy groups were perceived as more active in lobbying plans for increased enrollment in states with mandatory enrollment than in states with voluntary enrollment. In states with voluntary enrollment, access to managed care plans was facilitated when administrators believed the technique would improve overall plan management. For example, nearly two thirds of plan administrators in this group cited better management of costs and utilization, improvements in referrals to specialists and coordination of services as reasons for enrollment. Furthermore, increasing plan size was nearly three times as likely to be given as a reason for enrolling the SSI-disabled population in plans in voluntary compared to mandatory states (60 percent to 23 percent, respectively).

Administrators in fully capitated plans, compared to those in plans with partial capitation, also were more likely to see managed care as a useful tool for improving overall plan management. About 70 percent of administrators in fully capitated plans cited management reasons as encouraging enrollment of persons with disabilities, compared to about 50 percent of administrators in partially capitated plans.

Enrollment in, and access to, managed care plans also varied by type of plan. State mandates were more frequently given as a reason for SSI enrollment by administrators in HMOs than in IPAs. About half of HMO administrators reasoned that enrollment of the SSI-disabled would improve coordination of services, and would better manage costs and utilization. In IPAs, improved organization was more often noted than better cost and utilization management. PCCM administrators were more likely to cite state mandates, increasing enrollment and better cost management than managers of other types of plans. Overall, managing costs was a motivating factor for HMO administrators, and improving coordination of services was more often noted by administrators of IPAs.

Some reasons for enrollment were strongly affected by state enrollment policy and capitation strategy. For example, plans in voluntary states were significantly more likely than those in mandatory states to accept SSI-disabled clients to increase plan enrollment (63 percent vs. 21 percent) although earlier it was noted that plans in mandatory states actually enrolled more SSI clients. Plans with partial capitation arrangements were significantly more likely to encourage enrollment of this group to better manage costs and utilization. These differences were statistically significant.

The Role of Advocacy Groups

Some state Medicaid officials had cited the importance of disability advocacy groups in improving or impeding access to managed health care for people with disabilities. While disability advocacy groups may be quite visible at the state level, managed care plan administrators were less likely to be aware of the disability groups. As Table 12 shows, plan administrators related little direct impact of disability advocacy groups on actual plan operation. For example, few plan administrators (14 percent) reported that advocacy groups had actively lobbied them to enroll SSI-disabled adults. In fact, 60 percent reported that advocacy groups had had no effect on the plan's ability to provide services to the SSI-disabled. Not even half (45 percent) said advocacy groups improved plan visibility.

Most administrators did not see advocacy groups as hostile to plan goals. More than 60 percent of the administrators said that advocacy groups had assisted SSI clients in obtaining plan services, and almost 75 percent said advocacy groups presented a fair representation of the needs of SSI-disabled adults. Between a quarter and a third indicated that advocacy groups helped tailor services for persons with MR/DD, mental illness, or physical disability.

A minority of administrators had negative perceptions of advocacy group actions. About 40 percent said advocacy groups tended to demand more services than the plans could afford to provide. A relatively scant 20 percent of administrators reported that advocacy groups had threatened the plan with legal action.

Advocacy groups were perceived to have been more active in states with mandatory than voluntary enrollment requirements, especially in tailoring services for the diverse segments of the population. Half of administrators in mandatory states who responded to these questions, compared to 22 percent in voluntary states, reported that advocacy groups had helped to tailor services for persons with physical disabilities in their plans. Forty percent, compared to 18 percent, said this was the case, as well, for persons with MR/DD. Advocacy groups were also reported to be somewhat more of a force in fully capitated than in partially capitated plans. Almost half of fully capitated plans indicated advocacy groups had an effect on the delivery of services, assisting SSI clients to secure plan services (71 percent), improving plan visibility (52 percent), and helping tailor plan services. Fully capitated plans were also statistically significantly more likely than partially capitated plans (38 percent vs. 14 percent) to have worked with advocacy groups. Further, 45 percent of administrators in fully capitated plans said advocacy groups helped persons with physical disability as compared to only 9 percent in partially capitated plans.

Barriers to Enrollment

Plan administrators were also asked to identify specific barriers to enrollment in their plans for persons with disabilities. Table 13 arrays perceived barriers by state enrollment, plan capitation category and then by plan type. In general, very few administrators noted

major barriers and there were no statistically significant differences by enrollment or capitation type. About one third said there were no barriers to enrollment; specific client needs to accommodate a disability might be a barrier, cited by 15 percent of administrators; and 10 percent or fewer mentioned changing the provider relationship (10 percent), difficulties establishing eligibility (9 percent), problems marketing to this group (9 percent), or transportation problems (6 percent).

Although few specific barriers were cited, there were some differences by state enrollment type and plan capitation category. For example, administrators from plans in mandatory states mentioned more barriers than those from voluntary states. It was more difficult for some clients in mandatory states to have disability needs met (21 percent vs 11 percent). Even though managed care was mandatory in some states, interpreting eligibility criteria was more often mentioned as a problem in plans in these states than in plans in voluntary states (15 percent vs 5 percent). Administrators from plans in voluntary states were more likely than those from mandatory states to say there were no barriers to enrollment for persons with disabilities (41 percent vs 33 percent).

Changing providers seemed to be more of an impediment in fully than partially capitated plans (13 percent vs 4 percent), but determining eligibility was more problematic in the partially capitated than in the fully capitated plans (15 percent vs 6 percent). Respondents from fully capitated plans were more likely to mention difficulty marketing to and transportation difficulties for persons with disabilities as barriers than administrators from partially capitated plans.

Examining barriers to enrollment by plan type, it can be seen that administrators in IPAs were more likely to say there were no barriers than those in HMOs, but IPA administrators more often mentioned specific barriers. While 10 percent of HMO respondents said changing providers was a barrier, 18 percent of IPA administrators noted this. Furthermore, IPA administrators were more likely to see marketing to persons with disabilities as a problem than those in HMOs (12 percent vs 5 percent). However, transportation was seen as a bigger issue among HMO than IPA administrators (14 percent vs 0). CMHC administrators were significantly more likely to mention eligibility issues as a barrier to enrollment than any other type of plan administrator.

In summary, plan administrators were more likely to enroll persons with disabilities when the state mandated it. While advocacy groups were more active in mandatory states, their actions seem to have a limited effect on the enrollment of clients with disabilities, overall. In plans with full capitation, administrators enrolled clients with disabilities to improve overall plan management. This was not so much the case in partially capitated plans where administrators were less sanguine than those in fully capitated plans about improved management. Another difference was that health care providers more often requested care for this population from fully capitated plans than from partially capitated plans. Finally, administrators in HMOs more often mentioned enrolling persons with disabilities to improve

managing costs while those in IPAs were more likely to cite improving coordination of services.

Quality of Medicaid Managed Care for SSI-Disabled Population

Administrators were asked a number of questions about what works well in their plans, what changes they would like to see, what advice they would give to other plans considering enrolling SSI disabled adults, and what the state could do to improve services to this group. Many answers had to do with financing issues, which will be discussed in the next section, but about a third responded that improving coordination of services offered a major improvement in service delivery to persons with complex needs due to their disabilities. Others mentioned that applying managed care criteria to this complex population had led to the development of innovative programs, allowed the plans to be more responsive to special needs of the population, and increased the range of services available to them. Three out of four mentioned at least one aspect of the plan that was working well for persons with disabilities. In general, administrators in HMOs were more likely than those in IPAs to emphasize improved coordination, a wider range of services, and increased access. Those in IPAs noted an improved referral network for patients with disabilities and were somewhat more likely to mention the development of innovative programming to address their needs.

Financial Risks and Costs

Many plan administrators in states with mandatory and voluntary enrollment, in plans with full or partial capitation, and across plan types commented, in one way or another, that they were concerned about the financial risks to their plans of serving persons with serious disabilities. Although many plans received state capitation payments that were higher for clients with disabilities, numerous respondents worried that existing rates were based on insufficient information and would be inadequate.

The Adequacy of Capitation Rates

Despite concerns expressed about plan risk, about 63 percent of administrators reported that rates for AFDC and SSI clients were at least somewhat adequate. Fewer respondents could answer questions about adequacy of rates for persons with different types of disabilities, because they didn't collect data according to type of disability. However, among those who did respond, almost 60 percent said SSI rates were adequate for clients with physical disabilities, 53 percent concurred for SSI clients with mental illnesses, and 45 percent agreed rates were adequate for clients in the MR/DD category.

Administrators in states with mandatory enrollment were more likely to be satisfied with their capitation rates than those in states with voluntary enrollment. Similarly, those in fully capitated plans were more likely to find capitation rates satisfactory than administrators in partially capitated plans.

Examining these data by type of plan, very few PCCM providers (14 percent) felt capitation rates were adequate for their AFDC and SSI clients. While the majority of HMO administrators reported rates were somewhat adequate, more IPA administrators were relatively satisfied with Medicaid rates. Differences were most pronounced between administrators' assessment of the adequacy of rates for persons with physical disabilities. In HMOs, 50 percent of administrators reported rates to be somewhat adequate; in IPAs fully two thirds of respondents agreed. These results, displayed in Table 14, are statistically significant.

One indicator of how well managed care plans are doing in serving persons with disabilities was found in administrators' projections of future enrollment plans for this group. Most health plan administrators appeared to be relatively satisfied with enrolling persons with disabilities on SSI into managed care plans (see Table 15). The majority (56 percent) reported they would continue to enroll members of this group into their plans. Two out of five said they would, in fact, increase the numbers of these enrollees in the future. Very few administrators (3 percent) reported that they would either restrict the number of future enrollees, and even fewer (1 percent) said they would stop serving this population. Most also were satisfied with the number of services provided to persons with disabilities on SSI. Only 16 percent related they would increase the range of services for persons with disabilities.

Although there are some differences in making future plans for SSI-disabled adults by type of state enrollment, plan capitation category, and type of plan, none of them is statistically significant. In states with mandatory enrollment, it is not surprising that just less than two thirds of plan administrators expected to continue their plan as it is, and in about a third of plans, administrators hoped to increase enrollees. However, the majority of administrators in states with voluntary policies also intended to continue their present enrollment strategy and nearly half planned to increase the number of SSI enrollees.

Similarly, somewhat more than half of administrators in fully capitated (55 percent) and partially capitated plans (60 percent) reported they would continue their plans as is. It is only comparing responses between administrators in fully and capitated plans about increasing the number of SSI enrollees that any difference approaches statistical significance ($p=.08$). In fully capitated plans, 49 percent of administrators indicated they would increase SSI enrollees whereas in partially capitated plans only 28 percent concurred.

Between 50 and 60 percent of administrators in HMOs, IPAs, PCCMs and other types of plans would maintain present enrollment strategy. However, in terms of increasing the number of enrollees, there is some indication that HMO and IPA administrators (52 percent and 47 percent) were somewhat more likely than PCCM and other administrators (38 percent and 34 percent, respectively) to add SSI enrollees.

Multivariate data analyses were carried out and indicated some patterns in attitudes and experiences of those who would continue the plan as is and those who would increase

SSI-enrollment. As these results were not statistically significant, the findings are summarized and the data are not shown. A majority of plans intended to continue, rather than increase, their current level of participation in the state's Medicaid managed care program for the SSI-Disabled population. Plan administrators who would continue often worked in CMHCs; they cited a state mandate for enrolling the SSI-Disabled recipients in their plan; and they reported SSI recipients in their plans were satisfied. Further, they reported that their plan improved care coordination for this population, and that the SSI-Disabled population did not use services disproportionately when compared to AFDC recipients. Administrators who would increase participation levels wanted to increase plan enrollment. Although they did not know how satisfied clients were, they had had some experience with clients appealing service denials. They also thought the SSI-Disabled population did not require more costly services than the AFDC population.

4.7 Decision Points

Like the states, managed care plans confront important and interconnected decisions about providing health care services to the SSI-disabled adult population. They concern (1) future plans for including SSI enrollees in the plan, (2) carving out or integrating necessary services, and, perhaps most importantly, (3) designing acceptable reimbursement strategies. Similar to the state, plan decisions are influenced by managed care experience, the impact of Medicaid as a primary funding source for people in the SSI category, client and provider culture about access to care, and the growth of managed care in the state and the county. The objective of the state is adequate and affordable social welfare. Managed care plans also subscribe to social goals; however, their primary objective is to remain competitive in the marketplace.

a. State Regulation, Capitation Decisions and Reimbursement Design

Mandatory state policy was expected to continue to influence coverage for SSI clients. Administrators were more attuned to financial incentives as they were embedded in capitation strategy or plan structure. While Medicaid clients comprised a large portion of plans' businesses, relatively few clients with SSI eligibility participated in managed care plans. Although plans in states with mandatory enrollment rules accepted SSI enrollees in principle, in practice many such clients did not join because of existing specialty provider relationships, reluctance of primary care providers to serve them, or exclusion due to eligibility for other government programs, such as Home and Community Based Waivers or Medicare. For example, while the majority of plans accepted concurrent Medicaid and Medicare beneficiaries, this was significantly less likely to be the case in mandatory states.

While mandatory state policy resulted in a somewhat higher proportion of SSI enrollees, plan administrators in these states did not know more about SSI clients. Regardless of mandatory or voluntary state policy, few administrators responded to questions about client demographic characteristics, satisfaction of SSI clients, or the role of advocacy groups. If a goal of mandating managed care enrollment was to increase the positive

motivation of plans to enroll SSI clients, this goal was not met. Plan administrators in voluntary states were more likely than those in mandatory states to give constructive reasons for enrolling SSI clients. Administrators in mandatory states said they enrolled SSI clients to comply with the state regulations. Respondents from voluntary states more often enrolled these clients to benefit their plans, i.e., to increase plan enrollment, to manage costs and utilization better, and to improve coordination of services.

Reimbursement design had a stronger effect than regulation on providing services to the SSI population. Fully capitated plans, compared to partially capitated plans, were more likely to have a cadre of providers that specialized in providing services to SSI enrollees, were larger and served a much higher proportion of SSI enrollees, were less likely to impose a cap on Medicaid and SSI enrollees, and tended to enroll concurrent beneficiaries. Data reporting capacity was more complete, and involvement with disability advocacy groups was higher.

As there is a strong relationship between capitation strategy and plan structure among survey respondents (all HMO and IPA plans had full capitation; all PCCM and CMHC plans were partially capitated), it is interesting to note variation among plans with similar capitation design. Eligibility issues were more of a barrier for HMOs than for IPAs; better service coordination was perceived as more of a benefit among HMOs than IPAs. Risk was more often shared in HMO plans than in IPAs, PCCMs, or CMHCs. Perhaps related to lower risk sharing, HMOs were less satisfied than IPAs and CMHC plans with the adequacy of state capitation rates for AFDC and SSI clients. Concurrent beneficiaries were more likely to be enrolled in HMOs and PCCMs than in IPAs or CMHCs. Service availability and utilization also varied by plan type. HMOs provided more services under their capitation rates, but IPAs were more likely to cover services needed by persons with serious disabilities, particularly mental health services. PCCM rates covered many fewer services than either HMOs or IPAs.

b. Carving Out or Integrating Services

Service provision generally varied by plan structure. Plans with the most centralized structures, HMOs and IPAs, included the broadest range of services in their capitation rates leading toward integration of services for SSI-disabled clients. CMHC plans were carve outs and only provided mental health services. PCCMs were in between: they offered few services in their capitation rates but had the most flexibility for providers who served SSI enrollees. Although states had found few HMOs to accept the SSI population, HMOs that did had fairly comprehensive service packages. States were considering increasing the participation of PCCM providers in managed care offerings, but many PCCM respondents appeared reluctant to increase their role because of concerns about treating patients with complex medical problems and potential high costs. Plans to include specialty care providers as primary care case managers for complex clients might attract more PCCM participants, especially if risk sharing arrangements can be worked out.

c. Expanding Enrollment of SSI Clients

Overall, health plan administrators accepted some enrollment of clients with SSI benefits in Medicaid managed care, but less than half wanted to increase SSI enrollment. The relatively low participation of providers in serving SSI enrollees through managed care arrangements demonstrates the importance of reimbursement design. SSI enrollees were seen as requiring more referrals, fewer primary care services and more costly, specialty services. Most providers who participated in managed care for this population shared risk for losses or surpluses due to specialty care costs, and they maintained stop loss insurance.

A goal for the majority of administrators was to manage costs better for the SSI population. However, few plans tracked both SSI costs and client demographic characteristics that influence utilization. Although plan providers were generally positive about managed care for SSI enrollees, and a substantial minority said the plan allowed better coordination of services, few mentioned that the plan had actually resulted in a decrease in hospital use, another cost indicator. Client demographic data are vital for evaluating managed care plan access, adequacy of payment rates, and quality of outcomes for persons with disabilities. The lack of these data highlight the need for more comprehensive and user friendly data systems in managed care plans.

Indeed, a major finding of the plan administrator survey was the limited information available about the true costs and benefits of serving people with disabilities who received SSI benefits. The social goals of increasing access to and improving quality of care for the SSI population will be better met when plans have better data for evaluating the impact of managed care strategies on providing quality health care at an acceptable financial risk.

5. Discussion

a. Overview of Results

Persons with disabilities receiving SSI benefits account for a disproportionate share of Medicaid expenditures. SSI non-aged beneficiaries with disabilities account for about 15 percent of the Medicaid population but more than 35 percent of Medicaid expenditures. State policymakers have enrolled Medicaid recipients in managed care plans to control expenditures. At the outset of our study, 16 states enrolled the SSI-disabled population in Medicaid managed care plans. In the results presented here, we used qualitative and quantitative methods to understand more about the state policies that are promoting Medicaid managed care enrollment for working age adults with disabilities and the perceptions administrators of capitated health plans have about this trend.

Several major findings result from the research presented here. First, although most states suggested they had developed Medicaid managed care plans to promote access, ensure quality and manage program costs, there was considerable variability among states in the types of managed care programs they designed to achieve these objectives. One explanation for this trend may be that states had less success than may have been anticipated in enrolling the SSI-disabled in capitated plans. As a result, other potentially more flexible models were also developed, although no one model could be identified as preferable to the others. In addition to variability in plan type, there were also numerous differences among states in how the service, population or geographic limits of the plans were defined.

Second, successful development of Medicaid managed care plans for the SSI-disabled population is dependent on provider recruitment. Medicaid programs face significant barriers in encouraging providers to participate, some of which stem from historical problems with the Medicaid program such as low reimbursement rates and slow bureaucratic processes. Providers do not overlook these long-standing complaints in order to participate in Medicaid managed care programs. Furthermore, providers expressed great concern about their financial exposure in caring for the SSI-disabled population within the context of managed care and capitation.

We found both mandatory and voluntary policies among the states. Overall, more states had mandatory policies, but programs that served the SSI-disabled population were more prevalent in voluntary states. In states with mandatory enrollment in Medicaid managed care plans, capitated plans were likely to be smaller, non-profit, privately owned plans with fewer years of experience in providing managed care services. They also enrolled larger numbers of SSI-disabled recipients than plans in states with voluntary enrollment. Nearly all plans suggested they enrolled the SSI-disabled population because state policy mandates or encourages that the plan be available to Medicaid recipients. However, at least half of the plans capped the number of SSI-disabled they would enroll. Despite this finding, few plan administrators identified barriers to enrolling the SSI-disabled population in capitated plans.

Service availability and utilization varied by plan type. HMOs were more likely to include more services in their capitation rates, but IPAs were more likely to cover services needed by persons with serious disabilities, especially mental health services. Plan administrators believed that SSI-disabled recipients were more likely to be frequent users of more costly and specialty services such as hospital inpatient, support services and mental health services. The majority of HMOs absorbed risks for losses or profits, while more than half of the IPAs, PCCMs, CMHCs, and other types of plans shared risks with the state for the costs of this population. A majority of administrators of capitated plans intended to continue, rather than increase, their current level of participation in the state's Medicaid managed care program for the SSI-disabled population.

Together, these results suggest that there is considerable variation among and within states in the development and implementation of Medicaid managed care programs for the SSI-disabled population. However, there is no one model that is superior to the others, and the use of a capitated model for persons with disabilities has not been well tested. It appears that administrators of capitated plans have little intention of significantly increasing enrollment of the SSI-disabled population. For this reason, some states are turning to Primary Care Case Management and other models to increase enrollment in Medicaid managed care plans.

b. Policy Implications

A number of policy implications result from our analyses. First, states would benefit from learning more about the SSI-disabled population when developing managed care plans for this population. Few of the state policymakers we interviewed had analyzed available data, or collected person-level data from managed care plans. Policymakers and providers have little knowledge of the population for whom they are designing managed care options, and do not understand how health care needs vary among sub-groups within the population, even though persons with a cognitive disability may require a different benefit package than persons with a physical disability. Without a better understanding of the differing attributes of this population, it may be impossible for states to know what managed care plan characteristics will best meet the needs of the SSI-disabled population.

Second, the plans we surveyed were not planning to significantly increase enrollment of the SSI-disabled population. However, at the same time, states indicated an interest in enrolling all Medicaid recipients in managed care plans. States will need to develop creative methods to attract providers who will be willing and interested in serving a population of adults with complex health care and support needs. Already, there are indications that states are promoting the use of PCCM models that are not capitated. However, it may also be beneficial if states pursue alternative models, perhaps using a network of providers that already provide services to people with disabilities, rather than attempt to mainstream people with disabilities into plans developed for populations with less complex health care needs.

States may also achieve greater growth in managed care for the SSI-disabled population if they would address providers concerns about financial risks. Alternative reimbursement models that limit the financial risk for providers may more successfully encourage their participation.

Table 1: Percent of Medicaid Managed Care Plans the Serve the SSI-Disabled Population by Plan Type, State Enrollment Type, and Capitation Category

Enrollment and Capitation	All Plans Percents (N=79)	HMOS (N=21)	IPAS (N=17)	PCCMS (N=9)	CMHCS (N=11)	Others# (N=21)
State Enrollment type (N=78)	100.0	26.6	21.5	11.4	13.9	26.6
Mandatory (N=36)	46.2	33.3	52.9	12.5	81.8	47.6
Voluntary (N=42)	53.8	66.7	47.1	87.5	18.2	52.4*
Capitation category (N=79)	100.0	26.6	21.5	11.4	13.9	26.6
Full (N=53)	67.1	100.0	100.0	0.0	0.0	71.4
Partial (N=26)	32.9	0.0	0.0	100.0	100.0	28.6*

Others plan type included mixed plans with more than one configuration and other plans.

* Differences are statistically significant at p=.05 or less.

Table 2: Plan Tax Status, Ownership, and Selected Physician Characteristics by State SSI-Disabled Enrollment Type and Plan Capitation Category

Plan Organization	All Plans	Enrollment (N=78)		Capitation (N=79)		Plan Type				
		Mandatory (N=36)	Voluntary (N=42)	Full (N=53)	Partial (N=26)	HMOS (N=21)	IPAS (N=17)	PCCMS (N=9)	CMHCS (N=11)	Others (N=21)
Percent tax status (N=78)	100.0	46.2	53.8	67.1	32.9	26.6	21.5	11.4	13.9	26.6
For profit (N=27)	34.6	19.4	46.3	30.2	44.0	23.8	35.3	87.5	0.0	42.9
Non profit (N=51)	65.4	80.6	53.7*	69.8	56.0	76.2	64.7	12.5	100.0	57.1*
Percent ownership (N=79)	100.0	46.2	53.8	67.1	32.9	26.9	21.8	10.3	14.1	26.9
Private (N=59)	74.7	58.3	88.1	79.2	65.4	71.5	88.2	100.0	18.2	85.7
Public (N=20)	25.3	41.7	11.9*	20.8	34.6*	28.6	11.8	0.0	81.8	14.3*
Percent of plans where providers may refuse SSI-disabled (N=73)	9.6	14.3	5.3	8.2	12.5	0.0	6.3	0.0	18.2	20.0*
Percent of plans where some providers see disproportionate number of SSI-disabled (N=65)	38.5	48.7	31.4	47.7	19.0*	35.3	50.0	16.7	0.0	68.4*

* Differences are statistically significant at p=.05 or less.

Table 3: Plan Size by State SSI-Disabled Enrollment Type

Plan Organization	All Plans	Enrollment (N=78)		Capitation (N=79)		Plan Type				
		Mandatory (N=36)	Voluntary (N=42)	Full (N=53)	Partial (N=26)	HMOS (N=21)	IPAS (N=17)	PCCMS (N=9)	CMHCS (N=11)	Others (N=21)
Median # plan total enrollees (N=77)	27,774	14,800	31,387	49,250	5,000	39,202	49,500	8,050	30	38,000
Median # Medicaid enrollees (N=77)	9,000	6,229	9,876	13,844	5,000	13,250	14,500	8,050	30	12,614
Median # SSI enrolled in plans (N=67)	415	450	404	936	141	1,036	317	296	30	505
Mean years in managed care (N=79)	10.2	8.0	12.0	12.9	4.7	15.2	9.5	6.9	2.6	11.2
Mean years in SSI managed care (N=75)	6.8	6.2	7.3	7.9	4.3	8.9	7.2	6.1	2.6	6.8
Median # physicians in plan (N=73)	175	80	200	819	12	322	1,140	40	5	740

Table 3: Plan Size by State SSI-Disabled Enrollment Type

Plan Organization	All Plans	Enrollment (N=78)		Capitation (N=79)		Plan Type				
		Mandatory (N=36)	Voluntary (N=42)	Full (N=53)	Partial (N=26)	HMOS (N=21)	IPAS (N=17)	PCCMS (N=9)	CMHCS (N=11)	Others (N=21)
Median # plan total enrollees (N=77)	27,774	14,800	31,387	49,250	5,000	39,202	49,500	8,050	30	38,000
Median # Medicaid enrollees (N=77)	9,000	6,229	9,876	13,844	5,000	13,250	14,500	8,050	30	12,614
Median # SSI enrolled in plans (N=67)	415	450	404	936	141	1,036	317	296	30	505
Mean years in managed care (N=79)	10.2	8.0	12.0	12.9	4.7	15.2	9.5	6.9	2.6	11.2
Mean years in SSI managed care (N=75)	6.8	6.2	7.3	7.9	4.3	8.9	7.2	6.1	2.6	6.8
Median # physicians in plan (N=73)	175	80	200	819	12	322	1,140	40	5	740

Table 4: Marketing to Clients by State Enrollment Type and Plan Capitation Category

Marketing Strategies to SSI Clients	All Plans Percents#	Enrollment (N=78)		Capitation (N=79)		HMOS (N=21)	IPAS (N=17)	PCCMS (N=9)	CMHCS (N=11)	Others (N=21)
		Mandatory (N=36)	Voluntary (N=42)	Full (N=53)	Partial (N=26)					
Mass media (N=80)	12.5	13.9	11.9	15.1	7.7	9.5	17.6	11.1	9.1	14.3
Mailings (N=80)	18.8	11.1	26.2	24.5	7.7	33.3	5.9	11.1	9.1	23.8
Door to door (N=80)	26.2	5.6	42.9*	18.9	42.3*	23.8	17.6	88.9	0.0	23.8*
Contact advocacy groups (N=80)	10.0	8.3	11.9	7.5	15.4	0.0	17.6	0.0	9.1	19.0
Contact providers (N=80)	18.8	16.7	21.4	26.4	3.8*	28.6	17.6	0.0	9.1	23.8
Contact thru local welfare office (N=80)	40.0	16.7	59.5*	47.2	26.9	52.4	41.2	44.4	9.1	42.9
Contact thru local social security office (N=80)	13.8	11.1	14.3	13.2	15.4	14.3	5.9	22.2	9.1	19.0

Percents do not total to 100.0 because plans may have more than one marketing strategy.

* Differences are statistically significant at p=.05 or less.

Table 5: Client Characteristics by State Enrollment Type, Plan Capitation Category, and Plan Type

Clients	All Plans Percents	Enrollment (N=78)		Capitation (N=79)		Plan Type (N=79)				
		Mandatory (N=36)	Voluntary (N=42)	Full (N=53)	Partial (N=26)	HMOS (N=21)	IPAS (N=17)	PCCMS (N=9)	CMHCS (N=11)	Others (N=21)
Cap on Medicaid recipients (N=78)	51.3	33.3	66.7*	39.6	76.0*	42.9	35.3	100.0	72.7	42.9*
Cap on SSI recipients (N=78)	15.4	16.7	14.3	7.5	32.0*	9.5	0.0	0.0	72.7	9.5*
Client age (N=76)										
18-34 (N=15)	19.7	20.6	17.5	19.6	20.0	21.1	11.8	25.0	18.2	23.8
35-44 (N=30)	39.5	48.6	32.5	47.1	24.0	42.1	58.8	12.5	36.4	33.3
45 or older (N=31)	40.8	31.4	50.0	33.3	56.0	36.8	29.4	62.5	45.5	42.9
Concurrent beneficiaries enrolled: Medicaid and Medicare (N=76)	85.5	77.1	92.7*	92.3	70.8*	100.0	76.5	100.0	36.4	100.0*
Consumer satisfaction measured (N=76)	82.9	85.7	80.5	84.6	79.2	85.0	76.5	71.4	90.9	85.7
SSI clients satisfied (N=77)	61.1	63.1	61.0	53.8	76.0*	45.0	58.8	62.5	90.9	61.9
Very or somewhat (N=47)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Not very (N=0)	39.0	37.1	39 0	46.2	24.0	55.0	41.2	37.5	9.1	38.1
Don't know (N=30)										
Advocates satisfied (N=76)	38.2	41.1	36.6	38.5	37.5	25.0	41.2	25.0	40.0	52.4
Very or somewhat (N=29)	2.6	0.0	4.9	1.9	4.2	0.0	0.0	0.0	0.0	9.5
Not very (N=2)	59.2	58.8	58.5	59.6	58.3	75.0	58.8	75.0	60.0	38.1
Don't know (N=45)										

* Differences are statistically significant at p=.05 or less.

Table 6: Ratio of Selected Services Offered to Services Included in Plan Capitation Rate

Selected Services	All Plans (N=79) Ratio	HMOS (N=21)	IPAS (N=17)	PCCMS (N=9)	CMHCS (N=11)	Others# (N=21)
Speech therapy (N=80)	68.4	95.2	88.2	22.2	0.0	81.0*
Psychiatric hospital (N=80)	68.3	85.7	94.7	0.0	27.3	81.0*
Prosthetics (N=80)	67.1	90.5	82.5	11.1	0.0	66.7*
Occupational therapy (N=80)	67.1	90.5	88.2	22.2	0.0	81.0*
Group psychotherapy (N=80)	64.5	66.7	64.7	33.3	100.0	57.1
Intermediate health care (N=80)	60.8	76.2	70.6	55.6	0.0	71.4
Skilled nursing care (N=80)	64.5	81.0	76.5	33.3	0.0	66.7*
Glasses (N=80)	58.2	76.2	58.8	55.6	0.0	71.4*
Day treatment (N=80)	55.7	38.1	52.9	11.1	100.0	71.4*
Substance abuse TX (N=80)	50.6	61.9	64.7	11.1	18.2	61.9*
Dental care (N=80)	38.0	57.1	58.8	0.0	0.0	38.1*
Personal assistance (N=80)	30.4	38.1	29.4	11.1	0.0	47.6
Respite care (N=80)	24.1	28.6	35.3	0.0	9.1	28.6

Others plan type include mixed plans with more than one configuration and other plans.

* Differences are statistically significant at p=.05 or less.

Table 7: Utilization of SSI Clients Compared to AFDC Clients

SELECTED SERVICES: Clients Use More	Better Describes SSI Clients	Better Describes AFDC Clients	No Difference	No Answer
Primary care services (N=80)	17.5	27.5	20.0	35.0
Specialty services (N=80)	48.8	6.3	12.5	32.5
Costly services (N=80)	43.8	2.5	18.8	35.0
Hospital inpatient (N=80)	42.5	8.8	15.0	33.8
Support services (N=80)	37.5	6.3	21.3	35.0
Coordination of non-medical services (N=80)	35.0	8.8	21.3	35.0
Psychiatric hospitalization (N=80)	27.5	12.5	21.3	38.8
Outpatient psychotherapy (N=80)	25.0	16.3	18.8	40.0
Substance abuse treatment (N=80)	17.5	21.3	18.8	42.5
Emergency services (N=80)	13.8	35.0	18.8	32.5
Dental services (N=80)	7.5	18.8	16.3	57.5
Family planning (N=80)	1.3	52.5	10.0	36.3
Physicians report fewer problems serving this population (N=80)	17.5	13.8	32.5	36.3
Health care providers other than physicians report fewer problems serving this population (N=80)	15.0	16.3	30.0	38.8

Table 8: How Frequently Are Any of the Following Service Decisions Appealed by SSI Disabled Adult Enrollees?

SERVICE DECISION: Denial of	Very to Somewhat Frequently	Not Very Frequently	Not At All	Do Not Know
Specialist referrals (N=55)	3.6	61.8	34.5	0.0
Requests for durable medical equipment (N=73)	5.5	41.1	26.0	27.6
Hospital length of stay (N=76)	2.6	27.6	42.1	27.6
Procedure location (Outpatient v. Inpatient) (N=76)	2.6	34.2	35.5	27.6
Mental health service (N=75)	5.3	42.7	21.3	30.7

Table 8: How Frequently Are Any of the Following Service Decisions Appealed by SSI Disabled Adult Enrollees?

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Specialist referrals (N=55)	3.6	61.8	34.5	0.0
Requests for durable medical equipment (N=73)	5.5	41.1	26.0	27.6
Hospital length of stay (N=76)	2.6	27.6	42.1	27.6
Procedure location (Outpatient v. Inpatient) (N=76)	2.6	34.2	35.5	27.6
Mental health service (N=75)	5.3	42.7	21.3	30.7

Table 9: Data Reporting Capacity by State Enrollment Type and Plan Capitation Category

Does Your Data System Track Service Utilization?	All Plans	Enrollment (N=78)		Capitation (N=79)		Plan Type (N=79)				
		Mandatory (N=36)	Voluntary (N=42)	Full (N-53)	Partial (N=26)	HMOS (N=21)	IPAS (N=17)	PCCMS (N=9)	CMHCS (N=11)	Others (N=21)
On a person-specific basis (N=73)	78.1	84.4	75.0	82.7	66.7	80.0	76.5	37.5	100.0	85.7
AFDC clients (N=54)	96.3	95.8	100.0	100.0	85.7*	100.0	100.0	83.3	75.0	100.0
SSI disabled adults, in general (N=58)	91.4	89.3	96.6	100.0	75.0*	100.0	100.0	83.3	60.0	100.0
MR/DD clients (N=15)	60.0	50.0	75.0	85.7	37.5	100.0	100.0	50.0	20.0	75.0
Mentally ill clients (N=22)	72.7	72.7	80.0	90.0	58.3	100.0	100.0	50.0	55.6	75.0
Physically disabled clients (N=17)	64.7	50.0	80.0	90.0	28.6*	100.0	100.0	50.0	0.0	0.0

* Differences are statistically significant at p=.05 or less.

Table 10: Capitation Rates and Risk Sharing Arrangements among Plans

Capitation Rates	All Plans (N=79) Percents	HMOS (N=21)	IPAS (N=17)	PCCMS (N=9)	CMHCS (N=11)	Others# (N=21)
Rate Setting (N=77)	100.0	100.0	100.0	100.0	100.0	100.0
State sets rates (N=43)	56.6	50.0	47.1	100.0	72.7	47.6
Plan and state negotiate rates (N=33)	43.4	50.0	52.9	00.0	27.3	52.4
Rates differ for AFDC and SSI-disabled enrollees (N=69)	83.8	83.3	76.5	100.0	60.0	90.5
Rates differentiated by						
Age (N=35)	97.1	100.0	100.0	83.3	100.0	100.0
Gender (N=25)	96.0	100.0	100.0	66.7	100.0	100.0
Disability (N=18)	94.4	100.0	100.0	80.0	0.0	100.0
Rates at least somewhat adequate for						
AFDC clients (N=71)	64.8	55.6	60.0	14.3	90.9	80.0*
SSI disabled adults (N=71)	62.0	55.0	64.3	14.3	100.0	63.2*
Stop loss insurance based on (N=50)	100.0	100.0	100.0	100.0	100.0	100.0
Individual consumer's utitilization (N=40)	80.0	88.2	78.6	80.0	50.0	75.0
Aggregate utilization N=8	16.0	11.8	7.1	20.0	50.0	25.0
Other (N=2)	4.0	0.0	14.3	0.0	0.0	0.0
Risk shared for losses or surpluses due to specialty care costs (N=72)	100.0	100.0	100.0	100.0	100.0	100.0
Risk not shared (N=29)	37.7	52.4	37.5	37.5	9.1	40.0
Risk shared (N=43)	62.3	47.6	62.5	62.5	90.9	60.0*

Others plan type include CMHCs (13.9 percent), mixed plans with more than one configuration (15.2 percent), and other plans (11.4 percent).

* Differences are statistically significant at p=.05 or less.

Table 11: Reasons for Enrolling SSI-Disabled Adults by State Enrollment Type, and Plan Capitation Category, and Plan Type

Reasons for Enrollment of SSI-Disabled	All Plans Percents	Enrollment (N=78)		Capitation (N=78)		Plan Type (N=79)				
		Mandatory Percents (N=36)	Voluntary (N=42)	Full (N=53)	Partial (N=26)	HMOS (N=21)	IPAS (N=17)	PCCMS (N=9)	CMHCS (N=11)	Others (N=21)
To comply with state (N=73)	86.3	91.2	84.2	86.0	90.9	90.0	75.0	100.0	87.5	90.0
To improve coordination of services (N=72)	58.3	52.9	62.2	50.0	73.9	47.4	56.3	57.1	90.0	52.6
To manage costs better (N=71)	57.7	47.1	66.7	47.9*	77.3	50.0	43.8	71.4	88.9	55.0
To manage utilization better (N=71)	56.3	47.1	63.9	46.8*	73.9	50.0	43.8	57.1	90.0	52.6
To better organize referrals to specialists (N=71)	53.5	47.1	58.3	45.8	68.2	42.1	50.0	57.1	77.8	52.6
To increase enrollment (N=72)	43.1	21.2	63.2*	41.2	50.0	42.9	31.3	71.4	42.9	45.0
Requested by SSI adults or their families (N=61)	36.1	32.1	37.5	34.9	35.3	38.9	26.7	50.0	33.3	33.3
Requested by health care providers (N=61)	32.8	37.9	28.1	28.6	42.1	23.5	28.6	33.3	50.0	37.5
Advocacy groups lobbied the plan (N=56)	14.3	22.2	7.1	14.6	14.3	12.5	14.3	0.0	28.6	14.3

* Differences are statistically significant at p=.05 or less.

Table 12: The Role of Advocacy Groups by Enrollment Type and Capitation Category

Advocacy Groups	All Plans Percents	Enrollment		Capitation	
		Mandatory (N=36)	Voluntary (N=42)	Full (N=53)	Partial (N=26)
Lobbied plan for SSI (N=56)	14.3	22.2	7.1	14.6	14.3
Improved plan visibility (N=40)	45.0	47.4	42.9	51.8	30.8*
Helped us tailor services, in general (N=46)	30.4	42.9	20.0	37.6	14.2*
MR/DD (N=37)	27.0	40.0	18.1	32.0	16.7*
MI (N=40)	22.5	33.3	13.6	23.1	21.4*
PD (N=40)	35.0	50.0	22.7	44.8	9.1*
Demanded more services than we can provide (N=40)	40.0	50.0	30.0	40.0	40.0
Threatened us with legal action (N=44)	20.5	22.7	18.2	24.2	9.1
Assist SSI clients (N=44)	61.4	68.2	54.5	71.0	38.5
Present fair representation of client needs (N=35)	74.3	65.0	86.7	80.0	60.0
Have had no effect (N=50)	60.0	45.8	73.1	54.2	73.4

* Differences are statistically significant at p=.05 or less.

Table 13: Barriers to Enrollment for SSI Clients by State Enrollment Type, Plan Capitation Category, and Plan Type

Barriers	All Plans (N=80) Percents	Enrollment (N=78)		Capitation (N=79)		Plan Type (N=79)				
		Mandatory (N=36)	Voluntary (N=42)	Full (N=53)	Partial (N=26)	HMOS (N=21)	IPAS (N=17)	PCCMS (N=9)	CMHCS (N=11)	Others (N=21)
No barriers seen (N=80)	36.3	33.3	40.5	34.0	42.3	28.6	35.3	33.3	36.4	47.6
Specific disability needs (N=80)	15.0	19.4	11.9	15.1	15.4	19.0	0.0	11.1	18.2	23.8
Changing provider relationship (N=80)	10.0	11.1	9.5	13.2	3.8	9.5	17.6	0.0	0.0	14.3
Eligibility issues (N=80)	8.8	13.9	4.8	5.7	15.4	9.5	5.9	0.0	36.4	0.0*
Difficulty marketing (N=80)	8.8	11.1	7.1	11.3	3.8	4.8	11.8	0.0	0.0	19.0
Transportation (N=80)	6.3	2.8	9.5	7.5	3.8	14.3	0.0	11.1	0.0	4.8

Table 14: Positive Aspects of Medicaid Managed Care Plans for SSI-Disabled Clients by Plan Type

What works well?	All Plans Percents (N=44)	Mandatory (N=36)	Voluntary (N=42)	Full (N=53)	Partial (N=26)	HMOS (N=21)	IPAS (N=17)	PCCMS (N=9)	CMHCS (N=11)	Others (N=21)
Mention some aspect of plan that works well (N=80)	71.3	83.3	64.3	73.6	69.2	66.7	64.7	44.4	90.9	85.7
Plan allows better coordination of services (N=80)	33.8	38.9	31.0	34.0	34.6	28.6	17.6	22.2	90.9	52.4
Plan now has wider range of services (N=80)	8.8	5.6	11.9	11.3	3.8	14.3	11.8	0.0	9.1	4.8
Plan provides increased access (N=80)	11.3	5.6	16.7	13.2	7.7	14.3	11.8	22.2	0.0	9.5
Plan has developed innovative programming (N=80)	11.3	22.2	2.4*	9.4	15.4	9.5	11.8	11.1	27.3	4.8
Plan shows decrease in hospital use (N=80)	7.5	11.1	4.8	0.0	23.1*	0.0	0.0	0.0	54.5	0.0*
Plan has improved referral network (N=80)	7.5	11.1	4.8	11.3	0.0	0.0	17.6	0.0	0.0	14.3

* Differences are statistically significant at p=.05 or less.

Table 15: Adequacy of Capitation Rates by State Enrollment Type and Plan Capitation Category

Clients	All Plans Percents (N=79)	Enrollment (N=78)		Capitation (N=79)		Plan Type (N=79)				
		Mandatory (N=36)	Voluntary (N=42)	Full (N=53)	Partial (N=26)	HMOS (N=21)	IPAS (N=17)	PCCMS (N=9)	CMHCS (N=11)	Others (N=21)
All AFDC clients (N=71)	64.8	65.6	64.1	66.0	62.5	55.6	60.0	14.3	90.9	75.2*
All SSI disabled clients (N=71)	62.0	69.7	55.3	63.8	58.3	55.0	64.3	14.3	100.0	57.1*
MR/DD SSI disabled clients (N=42)	45.2	41.7	46.7	57.1	21.4	45.5	62.5	0.0	50.0	57.1
MI SSI disabled clients (N=53)	52.8	65.0	45.5	56.7	47.8	41.7	60.0	0.0	90.9	53.8
Physically disabled SSI-adults (N=52)	59.6	75.0	50.0	61.3	57.1	50.0	66.7	14.3	100.0	61.5

* Differences are statistically significant at p=.05 or less.

Table 16: Future Plans for Enrolling SSI-Disabled Adults by State Enrollment Type, Plan Capitation Catagory, and Plan Type

	All Plans Percents	Enrollment (N=78)		Capitation (N=79)		Plan Type (N=79)				
		Mandatory (N=36)	Voluntary (N=42)	Full (N=26)	Partial (N=53)	HMOS (N=21)	IPAS (N=17)	PCCMS (N=9)	CMHCS (N=11)	Others (N=21)
Continue plan as is (N=77)	55.8	60.0	53.7	54.9	60.0	52.4	60.0	50.0	81.8	47.6
Increase enrollees (N=77)	41.6	37.1	46.3	49.0	28.0	52.4	46.7	37.5	18.2	42.9
Increase services (N=77)	15.6	20.0	12.2	17.6	12.0	14.3	13.3	25.0	0.0	23.8
Restrict enrollees (N=77)	2.6	2.9	2.4	2.0	4.0	4.8	0.0	0.0	0.0	4.8
Stop serving (N=77)	1.3	0.0	2.4	2.0	0.0	4.8	0.0	0.0	0.0	0.0

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APPENDIX A

Medicaid Managed Care Programs for the SSI-Disabled Population
The Case of California

I. Brief Overview of the State

California has a complex system of delivering health care to its Medicaid (Medi-Cal) population. Currently, they utilize three different capitated models. First, ten California HMOs (PHPs) receive a capitated payment from the state to provide comprehensive health services to enrolled Medi-Cal recipients. Medi-Cal also has 18 partially capitated Primary Care Case Management (PCCM) contracts. The HMOs and PCCMs are operational in 20 counties statewide, with the majority in the southern counties and San Francisco County. Currently, all enrollment in HMOs and PCCMs is voluntary. Finally, in addition to the HMOs and PCCMs, there are two County Organized Health Systems (COHS) in Santa Barbara and San Mateo counties. The COHS are fully capitated Health Insuring Organizations (HIOs) that contract with the state as a county-wide system to offer a wide range of services to all Medi-Cal beneficiaries in those counties. Providers within the COHS then contract with the county to provide services. The COHS are mandatory for AFDC clients and some other categories of Medi-Cal beneficiaries, but voluntary for SSI disabled Medi-Cal recipients. All counties also offer a fee-for-service system for those who either are ineligible for managed care or those in the voluntary categories (such as SSI disabled) who do not opt for managed care.

In March 1993, there were over 5 million Medi-Cal beneficiaries in the state. California estimates that during FY 1992-93, 628,500 of the state's Medi-Cal beneficiaries will be eligible for Medi-Cal through the Supplemental Security Income (SSI) program. The state has limited

information about the 628,500 disabled Medi-Cal beneficiaries in the state. Medi-Cal officials do know that approximately 28,000 have serious mental illness, 12,200 are enrolled in some form of non-nursing home long term care, and 68,850 are in nursing homes.

The state expects enrollment in managed care plans during FY 1992-93 to reach 626,500 Medi-Cal beneficiaries. SSI beneficiaries represent 37,397 of managed care enrollees. Of Medi-Cal beneficiaries in managed care, approximately 350,000 are enrolled in HMOs, 173,000 are enrolled in PCCMs, and 78,000 are enrolled in the two COHS. About 350 frail elders are enrolled in On Lok, the original model for the Program of All-inclusive Care for the Elderly (PACE), and two new PACE contractors. The number of individuals who become eligible for Medi-Cal benefits is increasing rapidly, although at least one interviewee suggested that the average length of eligibility for Medi-Cal benefits is less than one year. For instance, between August 1992 and March 1993 the number of Medi-Cal beneficiaries increased over 200,000 from approximately 4.8 million to over 5 million. Interviewees attributed this rapid increase to the poor economy of the state.

California is looking toward an extensive expansion in managed care. At the time of our site visit, interviewees indicated two methods for this expansion: the state planned to begin operating three additional COHS in Solano, Santa Cruz and Orange Counties between January 1994 and January 1995. In addition, eleven additional HMOs and many more PCCMs had expressed interest in contracting with the state to provide health care to Medi-Cal recipients. However, the recent Strategic Plan for expanding Medi-Cal managed care indicates some changes in strategy. Budget constraints have resulted in the state wanting even more expansion than would have been possible with a continuation of the current system of service delivery.

Many Medi-Cal recipients receive services through county health care systems. County hospitals, a major Medi-Cal provider, were concerned about the possibility of rapid managed care growth. They believed that their ability to continue to provide services would be constrained if the Medi-Cal clients they traditionally served became HMO and PCCM members. Consequently, after discussion with the counties and other interested groups, California's Department of Health Services (DHS) has developed a new strategic plan that reorganizes the way services are delivered to Medi-Cal recipients. The new Two Plan Model will begin on March 31, 1995 in 13 regions of the state designated for expansion. Under this model, each region will have only two plan options available to Medi-Cal beneficiaries: a COHS "look-alike" (the local initiative) and a non-government HMO (the mainstream plan). The local initiative and/or the mainstream plan can contract with the county hospital to be a service provider. With the development of this new model and other local initiatives, California plans to have one-half of the Medi-Cal population (estimated at 2.7 billion) in managed care by 1996, although early increases in managed care enrollment have not been as rapid as was expected.

California's Medicaid program operates several federal waiver programs, including the Program of All-inclusive Care for the Elderly (PACE), the COHS, the PCCM program, a few waivers for MR/DD clients, Geographic Managed Care in Sacramento and the Family Mosaic program for seriously emotionally disturbed (SED) children in San Francisco. The new Two Plan Model will also operate under waivers.

California's Medicaid program is part of the Department of Health Services. The Director of the Department of Health Services reports to the Secretary, Health and Welfare Agency a cabinet level position in the State. Reporting to the Director of the Department of

Health Services is a Chief Deputy Director of Programs who is responsible for the management of the many programs under the Department of Health Services umbrella. Medi-Cal is one of these programs, and is managed by a Deputy Director of Medical Care Services. Medi-Cal is organized around a central office located in Sacramento, the state capital. The Medi-Cal Central Office is made up of four divisions: Policy, Payment Systems, Field Operations and Managed Care. District offices are located throughout the state. Medi-Cal's managed care programs are planned and implemented in the Medi-Cal Managed Care Division through the Managed Care Expansion and Managed Care Operations branches.

II. History of Managed Care Development in California

Managed care plans first began in the private sector in California during the 1960s. During this early phase of managed care, several scandals about fraudulent marketing practices occurred. Consequently, the Waxman-Duffy Act was passed in 1972. This Act addresses marketing, access and quality of all HMOs operating in the state. After Waxman-Duffy was passed, Medi-Cal began participation in managed care. The California Department of Health Services (DHS) established their first Medicaid pre-paid contracts in 1973. These early contracts were solely with HMOs. As a result of the early scandals, the Department improved its own monitoring efforts. In addition, it was decided that managed care programs, commercial and Medi-Cal, should be monitored by another State Department. This was done through the passage of another piece of legislation, the Knox-Keene Act, in 1975, which called for licensing of all HMOs through the state's Department of Corporations.

In the late 1970s and early 1980s, Medi-Cal began to develop additional managed care options. In 1979 the PACE program began as a Medicare demonstration, and became a federal waiver program in 1983. Moreover, in 1981, the state passed legislation to establish PCCM pilot programs. The PCCM programs were conceived to be an interim step in managed care in the transition from fee-for-service to full capitation. However, since the first PCCM contract with the state in 1984, only one PCCM has actually made the transition to a fully capitated HMO. This is due in large part to stricter financial solvency requirements for HMOs, one mandate of the Knox-Keene Act and the federal requirement that most HMOs have at least 25 percent commercial members.

In addition to the HMOs and PCCMs, the state received a federal waiver in 1983 to develop its first COHS in Santa Barbara County. San Mateo County later also developed a COHS, which became operational in 1987. The state is currently in the process of developing three new COHS, in Solano, Orange and Santa Cruz Counties; a geographic managed care initiative in Sacramento; PACE programs in Sacramento and Oakland; and Family Mosaic in San Francisco.

In the counties with COHS, AFDC recipients must enroll and receive services from the county or a provider who contracts with the county to provide services through the COHS. Enrollment in the COHS by SSI disabled recipients is voluntary. Currently in the non-COHS counties, enrollment in either a PCCM or a HMO is voluntary for all categories of Medi-Cal recipients. If a recipient does not select a managed care plan, he/she is automatically placed in the fee-for-service Medi-Cal system. Effective January 1, 1993, the Department was given authority under state law to place AFDC recipients, Medically Needy recipients with no Share

of Cost, and Medically Indigent children who live in a county where HMOs and PCCMs are offered automatically in a managed care plan if they do not sign papers electing to remain in the fee-for-service system within 30 days after initial Medi-Cal eligibility determination. SSI disabled clients who do not make a selection would continue to be issued a fee-for-service Medi-Cal card unless they elect enrollment in a managed care plan.

There are some exclusions from managed care program enrollment in California. In the HMOs and PCCMs, Share of Cost groups, beneficiaries with End Stage Renal Disease (ESRD), those in need of major organ transplants, and those who have been in a long term care facility for more than one month cannot enroll. Also excluded from the PCCMs are those eligible for the California Children's Services Program and the Genetically Handicapped Persons' Program, programs for individuals with specific high cost, high risk conditions. California's eventual goal is to use the new two-plan model to expand managed care and eventually enroll all Medi-Cal recipients in managed health plans. Officials hope the expanded program will ensure access, mandate quality, and manage costs for this population.

California has never specifically excluded people with disabilities from its managed care programs. However, Medi-Cal managed care began for the AFDC population, and there is a limited number of persons with disabilities in managed care programs. Interviewees believe that DHS does encourage managed care plans to serve the SSI disabled population. They view managed care as an opportunity to provide better care and save money on disabled groups, especially persons with serious mental illness. However, the state knows little about the experience of disabled recipients in these plans. They have had some feedback from advocacy groups about the participation of disabled recipients; consumer advocacy groups in California

are quite vocal, especially in MR/DD. Although these groups have stated that they oppose mandatory managed care, most of their advocacy is addressed to the Department of Mental Health (DMH) and the Department of Developmental Disabilities (DDS). They view DHS as a payer rather than as a group that sets policy. However, advocacy groups for persons with physical disabilities, such as the World Institute on Disability (WID), have been encouraging Medi-Cal to provide more non-traditional services often necessary for persons with disabilities, such as personal care. These groups are also asserting a need for more control over their physical health and the manner in which services are provided. They would like to have money allocated to peer case management by Medi-Cal. This would give disabled recipients greater control over the services they choose to purchase.

III. Financing and Reimbursement

California's HMOs are required to provide inpatient and outpatient hospital services, physician services, lab and x-ray, prescription drugs, EPSDT, therapy services, home health care and durable medical equipment, hearing, vision, family planning, transportation and limited nursing home care. The HMO is at full risk for all services; the only optional service is dental. COHS provides all of the same services as the HMO at full risk, except for the screening component of EPSDT, which is provided by the county Child Health and Disability Prevention Program and the Medi-Cal fee-for-service system.

California PCCMs use an unusual model of financing. They are paid a partial capitation payment and must provide case management and a group of other outpatient services including primary care visits, home visits, immunizations, emergency room visits, psychiatry and urgent

care on site. Moreover, for an additional capitation payment, the PCCM can select to accept the risk for seven additional outpatient service packages: obstetrics, pharmacy, pathology and laboratory services, radiology, vision, medical transportation and certain therapies (physical therapy, occupational therapy, speech therapy and audiology, psychology). The state has found that as PCCMs gain experience, they typically increase the number of services included in their capitation. However, all inpatient care for PCCM enrollees is fee-for-service, and the primary care physician is expected to control inpatient utilization.

Capitation rates are based on age, sex, geography and aid category. The state plans to combine the rate categories for blind and disabled recipients because the number of beneficiaries in these categories is so small. Rates differ substantially for the AFDC and SSI disabled populations. SSI disabled rates are often three to four times the AFDC rate. However, SSI disabled capitation rates are relatively stable, given that this population is the most stable, long-term Medi-Cal population. The base for the AFDC rates has been decreasing due to an increase in a new, healthier client population becoming eligible for Medi-Cal. This change in the Medi-Cal population is a result of the poor economy and consequent number of jobs lost in the state, forcing previously employed and healthier individuals onto public benefits.

Capitation rates are calculated for each service package. Rates are calculated for several categories in each county: AFDC, Aid to the Disabled (often SSI), SSI/Medicare A only and SSI/Medicare A and B (QMBs), Medically Needy-Share of Cost, Medically Needy-No Share of Cost, Medically Indigent, Refugee. Adjustments are also made for age and gender. To calculate capitation rates, the state uses paid claims based on two year old data trended forward. The costs for each type of service are summed to arrive at the base capitation amount for each

aid category. The state sets the capitation rate at 97 percent of this amount for HMOs and at 99 to 100 percent of this amount for Santa Barbara COHS. At San Mateo COHS, the capitation rate is negotiated with the state. PCCM rates are set actuarially at 95 percent of fee-for-service experience based on service package. Although the PCCM receives no case management fee for serving Medi-Cal clients, California has established a Savings Sharing plan as an incentive for PCCM providers. The savings sharing amount is based on a formula: expected fee-for-service cost for all services minus capitation plus the actual cost of non-capitated fee-for-service services. The PCCM receives one-half of any savings, DHS receives one-fourth and federal Medicaid receives one-fourth. Although we received conflicting opinions on the amount of savings sharing, it appears that savings sharing ranges from $4.50 to $7.00 per month per enrollee. Interviewees felt that the savings sharing plan has been an extremely effective incentive in encouraging providers to serve Medi-Cal clients.

Plans are protected from catastrophic costs in different ways, depending on plan type. HMOs must purchase a minimum of $25,000 stop-loss reinsurance, but usually buy between $50,000 and $75,000. PCCMs have the option of purchasing $10,000 in stop-loss reinsurance for the mandatory service package. PCCMs may also purchase additional reinsurance for any optional services for which they choose to accept risk. The COHS have the same options as the HMOs. For Santa Barbara COHS the risk limit is $75,000, and for San Mateo COHS the risk limit is $60,000. The state's reinsurance program takes the form of a contractual risk limit which is set by mutual agreement between the plan and DHS. The plan is reimbursed at fee-for-service rates if they exceed their risk limit. The capitation rate is reduced by the equivalent of the reinsurance premium. Plans may also purchase private reinsurance.

Although the state's managed care programs meet federal cost effectiveness requirements, the state no longer believes managed care can produce any significant short term savings. Interviewees viewed managed care more as a method to increase access and quality than to reduce costs. The margin for savings from managed care is limited, as the state already pays less than 46 percent of provider fee-for-service costs for outpatient services, and is 48th nationally in level of hospital compensation. California is 47th in spending per capita per beneficiary. One place the state does feel it may be able to save money with managed c ıre is through Targeted Case Management programs for disabled and high cost populations. Although the state believes that costs may initially increase if care is managed well, long-term savings should result from decreases in service utilization, use of specialists and inpatient admissions.

IV. Marketing

Currently, enrollment in California's Medi-Cal HMOs and PCCMs is voluntary and marketing to potential enrollees is the primary responsibility of the pre-paid managed care plans. However, the Department of Health Services (DHS) has conducted marketing efforts through Health Care Options (HCO) presentations at local welfare offices. Plan representatives also market door-to-door and mail plan information to beneficiaries. An additional marketing strategy that has been used by the PCCMs is to enroll the current fee-for-service patients of physicians in the PCCM through presentations in physicians' waiting rooms. The HCO program will eventually replace all door-to-door marketing.

There have been recent changes in managed care marketing techniques and enrollment processes. In 1992, a new law which allowed for more aggressive marketing of managed care

by the state was passed. As a result, once the necessary federal waivers are obtained, the HCO program will be enhanced and AFDC beneficiaries will have 30 days to choose either fee-for-service or a managed care plan. If no choice is made within 30 days, AFDC clients will automatically be enrolled in a managed care plan. SSI disabled clients, unlike AFDC beneficiaries, will automatically be placed in the fee-for-service Medi-Cal system unless they elect to enroll in a managed care plan. Until the new marketing law is implemented, AFDC clients who do not elect a health care option will automatically be placed in the state fee-for-service system. California views this change for AFDC clients to be automatically enrolled in managed care rather than fee-for-service as a first step toward enacting mandatory enrollment in managed care.

The COHS are mandatory for AFDC and some other categories of Medi-Cal recipients in the counties in which they are operational. Consequently, there is no marketing done for this managed care system. If a mandatory beneficiary does not choose a provider, one is assigned. For the SSI disabled population, clients who do not choose a provider within the COHS network remain in the county fee-for-service system and may elect to receive health care services outside of the county as well.

Interviewees suggested that plans have been more willing to enroll the AFDC population than the SSI population. Although plans have not "actively avoided" the SSI population, their marketing techniques are more likely to target the AFDC population. For example, HCO presentations are made at the welfare offices, where AFDC beneficiaries establish eligibility, while SSI disabled recipients receive their eligibility through the Social Security offices. They are thus less likely to encounter marketing representatives. In addition, door-to-door marketing

is targeted to areas with a large number of Medi-Cal recipients, who are far more likely to be in the AFDC, rather than the SSI disabled eligibility category. Moreover, interviewees suggested that SSI recipients are more likely to have their own providers, and thus be less likely to be interested in establishing a new provider relationship. There is anecdotal evidence, however, that plans may not encourage the enrollment of SSI recipients because of the risk they represent and that fee-for-services physicians encourage clients receiving both Medicare and Medi-Cal benefits (the dually eligible) to remain in the fee-for-service system because of the financial benefit to the physician. DHS attempts to monitor plans for selective marketing and believes that mandatory enrollment in managed care will decrease the potential for selection bias.

In 1991, DHS surveyed 1005 managed care enrollees and other Medi-Cal beneficiaries to determine the types of marketing that would encourage increased enrollment in managed care plans. DHS plans to alter marketing strategies based on the responses to the survey. DHS will be targeting two groups of Medi-Cal recipients: those who have some knowledge about managed care and have loose ties to the fee-for-service system, and those who have little knowledge about managed care. The Department will also increase the number of marketing materials published in languages other than English. Results of the 1991 survey indicated that the most common reasons Medi-Cal beneficiaries had for not enrolling in managed care plans were: lack of knowledge about managed care, the belief that it would cost money, not wanting to change physicians, current satisfaction with their medical care, or hearing of others' bad experiences with managed care.

California enrolls SSI recipients in managed care programs on a voluntary basis. Interviewees felt that enrollment in managed care increased access for these clients to primary

care and specialty services. Many SSI recipients have complex problems, and they often have difficulty obtaining care in the fee-for-service system. Interviewees thought that this was especially a problem for the developmentally disabled population. However, policymakers are also concerned that some of these complex problems should not be managed by a primary care physician. As an example of the way the Department plans to address this concern, interviewees said that the state is considering "carving out" certain groups of clients and offering special managed care programs for them. For example, they may offer a special managed care program for clients with serious and persistent mental illness.

V. Provider Participation

As described previously, ten California HMOs, 18 PCCMs and two COHS receive a capitated payment from the state to provide comprehensive health services to Medicaid recipients. The majority of SSI recipients that participate in managed care in the state are enrolled in these plans in limited numbers. There are a number of other HMOs in the state that have expressed interest in participating in Medicaid managed care, and interviewees anticipated at the time of our site visit that some new HMOs would begin enrollment this year. However, the new Two Plan Initiative has led to a moratorium on enrollment while plans for the development of the new model are finalized.

Provider issues are somewhat of a concern in California. Many physicians will not accept Medi-Cal because reimbursement rates are low; the last rate increase was in 1985. In addition, as noted previously, providers often encourage disabled clients, particularly those in the dually eligible category, to avoid managed care. There is a provider perception that

managed care and capitation mean less services for clients. However, due to the savings sharing program, the state has had little difficulty recruiting providers for the PCCMs, except for some specialty groups such as orthopedists. There are "hundreds" of providers in the 18 PCCM plans. Moreover, the Department continues to receive inquiries from HMOs about becoming Medi-Cal providers.

Another provider group with serious concerns about managed care is the county hospital system. County hospitals in California have traditionally been the provider of last resort for Medi-Cal and indigent clients. These hospitals are dependent upon Medi-Cal to subsidize their indigent care. They fear that managed care expansion would remove their base of insured clients, leaving them with only clients with no insurance. Consequently, they have mounted an aggressive campaign against managed care expansion.

Provider experience with SSI disabled clients varies by type of plan. Some PCCMs have extensive experience serving the disabled population, while others' experience with this group is quite limited. In addition, the HMOs are allowed to assign clients to primary care physicians with a specialty. Thus, many disabled recipients may be likely to see a few select primary care physicians in an HMO who are consistently assigned to or chosen by disabled clients due to reputation, interest or experience. COHS physicians are the providers with the most extensive experience in serving SSI disabled clients, as the COHS has the most inclusive and wide-ranging managed care program in the state.

VI. Quality of Care

The quality of the care delivered in California's Medicaid managed care plans is monitored and controlled in several ways. First, the Department will only contract with providers that are appropriately licensed and certified. Second, there is a strong facility inspection program for licensing. Through this program, site reviews are required before contracting. Physical accessibility for persons with disabilities is dealt with through the facility inspection process. The third quality monitoring mechanism is an annual medical audit at random sites to identify deficiencies in a range of services areas including pediatrics, adult visits, and routine obstetrical care. The state develops a corrective action plan based on this audit. Other quality monitoring procedures include quarterly site visits, biannual financial audits, investigations of complaints, required quality assurance programs in the plans, and reviews of disenrollments and emergency room visits. Different items are measured each quarter, and some monitoring is ongoing. All quality assurance programs must meet requirements originally established by Knox-Keene, including a documented formal quality review process, a utilization review process, peer and medical record review, and provider credentialing standards. Most deficiencies discovered through monitoring are deficiencies in paperwork compliance, rather than in quality of services provided.

Pre-paid health plans are required to have an enrollee grievance system. The plan must act upon a grievance within 30 days. However, no state review of grievances is required. Most complaints are about marketing, rather than medical or service related problems. There are few complaints from providers. Most complaints come from advocacy groups and AFDC beneficiaries. Interviewees could not recall a specific grievance coming from an SSI enrollee,

with the exception a problem early on in the Santa Barbara COHS. The reason for this grievance was that dually eligible and SSI disabled clients enrolling in the COHS were forced to choose a primary care provider who was not a specialist, even though these groups had ongoing relationships with specialists. The grievance was resolved by deciding that in cases where disabled clients in the COHS had ongoing specialist relationships, these clients did not have to switch to a primary care physician. Instead, they could use the Medical Director of the COHS as their point of entry into the system. The grievance at Santa Barbara was considered extremely unusual. For the most part, the COHS is considered to do excellent work and receives very few complaints.

A recent member satisfaction survey compared those Medi-Cal beneficiaries in managed care plans with those in the fee-for-service system. Both groups had a high level of satisfaction with the quality of their medical services. Those in the fee-for-service system indicated problems finding a doctor who accepted Medi-Cal; managed care plan members had none. Managed care plan members indicated a greater concern about the administrative process for obtaining services than those in fee-for-service.

The state works to resolve enrollee complaints rather than have the person disenroll from managed care. Clients in the COHS can change providers at any time. Currently, clients may disenroll from the PCCM or the HMO at any time, but they must call or go to the plan and fill out a form in order to do so. The most common reasons for disenrollment from the HMOs or the PCCMs are loss of Medi-Cal eligibility, wanting to return to a provider outside of the plan, or general dissatisfaction. The state requires that marketing materials indicate to clients their right to disenroll from managed care. The average net rate of disenrollment is 3 to 5 percent,

including those who lose Medi-Cal eligibility. Disenrollment data are collected by the Department. They plan to begin routinely publishing this information.

All of the current quality measures used by the Department are process measures. They are working to develop outcome and performance measures of quality. Interviewees believe that quality is higher in managed care than in the fee-for-service system. Physicians in managed care are reviewed and audited more closely. In addition, interviewees think that managed care can increase aceess and quality for SSI disabled beneficiaries.

VII. Utilization of Services

California's HMOs, PCCMs and COHS are responsible for managing the utilization of enrolled Medicaid recipients. The Department provides technical assistance in this area to the plans if necessary, but is not directly involved in implementing these policies. While managed care has shown decreased emergency room use of 5 percent overall for Medi-Cal clients and 1 to 4 percent for individual PCCMs, the state believes they have limited data on utilization and are not sure if the decrease in emergency room use is due to good case management or efficiencies or if it just reflects a lack of services or statistical sampling problems.

In the HMOs and PCCMs, primary care providers must approve referrals to out of plan providers and specialists. A special system of Treatment Authorization Requests (TARs) have been developed for this purpose. The state has established a system that rejects claims that have not been approved by a recipient's case manager. The primary care physician is usually the case manager in the HMO and the PCCM. In addition, the PCCMs access special case managers for some clients in need of extensive mental health services through the Short-Doyle mental health

program, a jointly funded state and county program, administered by the county, that targets Medi-Cal and medically indigent clients with chronic mental illness. Short-Doyle services in PCCMs are paid for by the fee-for-service system. Persons with developmental disabilities also have case managers through the Department of Developmental Disabilities. This person arranges most of the medical care for these beneficiaries. No prior authorization is required for emergency room visits, but the state makes it difficult for providers to get paid if they treat a non-emergency situation without appropriate authorization. All Medi-Cal cards explain the restrictions and have the name of the client's managed care plan on them.

In the COHS, the primary care physician is the case manager. The primary care physician controls use of specialty and ancillary services. Enrollees in the COHS can get emergency care from any provider at any time. Prior authorization is required for several types of service: any outpatient service that would require preauthorization if the client were in the county fee-for-service system; services referred to an out of county provider; non-emergency inpatient admission; and extension of inpatient stays. Santa Barbara COHS uses pseudoclaims and a special data system to monitor utilization. San Mateo COHS does not do as much utilization monitoring.

The Department cannot provide utilization information for each of the groups of clients with different types of disabilities. They are just beginning to identify their high cost clients using their Medicaid claims file to identify high cost clients in four counties for a new Medical Case Management program, a targeted case management program initiated in March 1993. Thus far, they have identified 1,700 clients who cost over $75,000 and 14,000 who cost over $25,000. Of the 1,700 clients using over $75,000 in medical services, 1,200 lived in Los Angeles County.

VIII. Data

California's Medicaid program does not receive person specific data for clients enrolled in pre-paid health plans. The plans do provide the state with utilization reports on a quarterly basis, an annual disclosure statement and quarterly fiscal reports. The utilization reports are not compiled or aggregated by aid categories. Most encounter data are not required. Interviewees thought that the managed care data currently collected are not meaningful. Little data analysis is done. The state does have good fee-for-service data, with encounters automatically reported through their claims processing system. California processes 164,000 claims per day and pays 222,000,000 claims per week.

DHS is in the process of developing a minimum data set to be required from managed care plans. They want to begin to get comparable information with the fee-for-service system to increase their monitoring and track whether plans are actually providing the preventive care they contract for. Types of data that will be required will include tapes of all paid and denied claims in plans with a fee-for-service component; encounter-level data; and aggregate reports on utilization, provider participation, access and quality.

California also hopes to develop a more sophisticated data system to measure outcomes by January 1994, and plans to enter into a contract with a university to analyze claims data to determine high cost groups by diagnosis and geography.

IX. Current and Future Issues

The Department is planning to undertake a major managed care expansion through several different avenues. First, in 1991, AB 336, the California Managed Care Initiative was

passed. This bill called for rapid expansion of managed care through several strategies: 1) increase the number of COHS and bring the Medi-Cal population in HIOs to 10 percent (the maximum allowed by federal statute); 2) develop managed care programs in specific geographic areas (the state refers to this as geographic managed care); 3) increase the number of HMOs; 4) increase the number of PCCMs; 5) managed care, rather than fee-for-service should be consider the mainstream plan; 6) mandatory enrollment should begin in January 1994; 7) lock-in periods for managed care plans. In 1992, SB 485 modified and expanded AB 336 with mandated enrollment changed to January 1993 and a fee-for-service managed care model with intensive case management for high cost clients.

As a result of AB 336 and SB 485, three new COHS programs are being developed: Solano County COHS will be operational in January 1994, Santa Cruz County COHS will be operational in July 1994, and Orange County COHS will be operational in January 1995. Geographic managed care plans are also being developed; geographic managed care will become mandatory for the entire AFDC population in Sacramento County once the program is operational. Other new programs and pilot projects under development at the time of the site visit included fee-for-service managed care programs for high cost clients, a special managed care program for seriously emotionally disturbed children, and a demonstration managed care program for dually eligible clients. One of the fee-for-service managed care models the state is considering developing may have a savings sharing component.

However, during April 1993, the state released a strategic plan for the expansion of managed care. Rather than expanding the existing HMO and PCCM programs, the way services are delivered to Medi-Cal recipients, even within managed care, will be reorganized through a

new Two Plan Model. The new Two Plan Model is scheduled to become operational on March 31, 1995 in 13 regions of the state designated for expansion. There will be a phase down of the existing HMOs and PCCMs, with no new enrollments in these programs after September 30, 1994. Under the Two Plan Model, each region will have only two plan options available to Medi-Cal beneficiaries: a COHS "look-alike," (the local initiative) and a non-government HMO (the mainstream plan). The waivers for the Two Plan Model will be submitted to HCFA in July 1994. With the development of this new model and other local initiatives (the three new COHS), California expects to have one-half of the Medi-Cal population (estimated at 2.7 billion) enrolled in managed care by 1996.

The state wants to move toward mandatory managed care for most categories of Medi-Cal beneficiaries as part of the new model. AFDC, Medically Needy-No Share of Cost, and Medically Indigent Children will choose between the local initiative and the mainstream plan. SSI disabled beneficiaries, as well as the dually eligible, foster children, and Share of Cost beneficiaries will have the option of remaining within the county fee-for-service system. Mental health services will be provided through the county mental health departments as part of an integrated, carved out mental health system for clients with serious mental illness. This will be a full risk, capitated program. Eventually, California would like to include SSI disabled clients in their mandatory managed care programs and completely eliminate the fee-for-service system. However, this is viewed as the next phase of managed care expansion.

Interviewees expressed uncertainty about how to integrate special populations into their managed care programs. California considers its special populations to include the elderly; persons with disabilities, particularly those with serious mental illness and those dually diagnosed

mental illness and substance abuse disorders; pregnant women; crippled children; and neonates. Interviewees thought the state needed to deal with the issue of defining disability and determining who the disabled are and how to provide the support services they need. Advocacy groups and persons with physical disabilities are urging the Department to make personal care a Medi-Cal benefit. If personal care does become a Medi-Cal benefit, the state can then provide support services to clients. All interviewees believed that programs should be tailored to meet the needs of special populations. Some thought the state should carve out these groups and develop special managed care programs specifically to meet the needs of people with disabilities. The state would like to include special populations in appropriate managed care, and eventually move to enrolling 80 percent of Medi-Cal beneficiaries in managed care. However, they recognize the need to address the special issues of high cost and disabled populations before this can be done successfully.

X. Summary and Lessons

California has had a long history of developing managed care programs. Some state officials believe that Medicaid managed care programs can be used to increase access to and quality of services for Medicaid recipients, and contain costs for the state. However, the state has limited evidence that can be used to support these claims, particularly with regard to the SSI disabled population. In addition, some interviewees thought the savings expected from managed care was unrealistic. Relatively few SSI disabled recipients have voluntarily enrolled in California's pre-paid managed care plans, and the state knows little about the experience of recipients who have been enrolled.

Medi-Cal officials believe, however, that further development of managed care plans, particularly special plans for people with disabilities, will give the state more information to refine its programs. Therefore, it is considering developing specialized programs for recipients who use mental health services, those dually diagnosed with mental illness and substance abuse disorders, seriously emotionally disturbed children, and other high cost clients through targeted case management and other strategies. In addition, the state is planning to expand its managed care program statewide, using the Two Plan Model, Geographic Managed Care, expansion of COHS, and possibly fee-for-service managed care in less densely populated geographic areas. State officials suggested that the primary reason they are expanding managed care plans is to improve access to and increase quality of services for Medicaid recipients. However, officials suggested they do not know enough about biased selection issues to determine the true costs of their managed care plans.

Interviewees pointed out several lessons for other states in developing managed care programs for Medicaid clients. First, they suggested initially putting healthier clients in managed care while looking at who the special populations are and what their needs are. HMOs are based on the medical model and are not set up to provide the social and behavioral supports often needed by individuals with disabilities. Officials believe that most managed care plans are not ready to adequately serve special populations. Second, they believe it is critical to get constituency and advocacy groups involved early on in the process. Program expansion is less difficult if states do this. Interviewees thought that the involvement of advocacy groups was especially critical for disabled populations, as these clients can create unique issues for managed care plans if they demand a specialist case manager. Third, it is crucial to have good data and

monitoring systems in place up front. Officials suggested establishing minimum data sets, monitoring with an eye for quality and underutilization and measuring outcomes. Fourth, it is important to provide safety nets and to consider the impact of expanding capitated managed care on safety net providers. If all Medicaid clients enroll in managed care and the county hospital is not a managed care contractor, these hospitals are left serving only the sickest and poorest populations. Finally, officials suggested choosing significantly populated geographic areas for capitated managed care development and expansion. They believe that there is room in managed care for fee-for-service models, and that sometimes capitation is not an option, particularly in areas with no a critical mass of Medicaid clients. They believe that states should consider experimenting with targeted case management and other forms of fee-for-service managed care as well as using capitated models.

Information Resources

Interviewees - California Department of Health Services

Vivian Auble, Chief, Contract Management Unit #2, Medi-Cal

Teri Barthels, Chief, Managed Care Policy Section, Medi-Cal

Jose Fernandez, Director of Medi-Cal

Roy Johnson, Uninsured Program, Program Development Section, Medi-Cal

Marilyn Marqua, Chief, Systems Support Unit, Medi-Cal

Byron Moss, Chief, Managed Care Programs Operations Section, Medi-Cal

Bob Murch, On-lok Program, Program Development Section, Medi-Cal

Jim Parks, Chief, Health Systems Financing Division, Medi-Cal

Sandra Pierce, Chief, Program Development Section, Medi-Cal

John Rodriguez, Chief Deputy Director of Programs, DHS

Alan Stolmack, Chief, Managed Care Initiative Project, Medi-Cal

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Medicaid Managed Care Programs for the SSI-Disabled Population
The Case of Colorado

I. Brief Overview of the State

Colorado utilizes two models for delivering managed health care to its Medicaid population. First, one Colorado HMO receives a capitated payment from the state to provide comprehensive health services to enrolled Medicaid recipients. In the past, a second HMO also contracted with the state to provide health care services to Medicaid recipients; however, this HMO contract was terminated in December 1992 because the state and the HMO physicians could not agree on capitation rates. The state and the HMO plan to negotiate and hope to recontract in the future. Colorado also operates a PCCM program, the Primary Care Physician (PCP) program, with 1,927 individual physician fee-for-service contracts and 24 health center contracts. Either an HMO or the PCP program operates in 58 of the 70 counties within the state. The 12 counties that have no managed care contractors are rural counties with physician shortages.

During FY 1991-1992, 242,379 persons in Colorado received Medicaid benefits. About 17 percent, or 42,254, of these beneficiaries were enrolled in an SSI disabled Medicaid eligibility category. Clients in the SSI disabled group can be in any of three Medicaid eligibility categories depending on age: Aid to Needy Disabled (AND) for persons up to age 60; Old Age Pensioners B (OAP-B) for persons aged 60 to 64; or Old Age Pensioners A (OAP-A) for persons aged 65 and older. Almost 50 percent of the total SSI disabled group, or 21,084

beneficiaries, also received Medicare benefits. There is also a separate Aid to Blind (AB) category for eligible individuals of all ages.

As of November 30, 1992, slightly more than half, or 125,178, of the state's Medicaid beneficiaries were enrolled in managed care. Another 36 percent, or 88,360 beneficiaries, were required to enroll, but had not yet selected a primary care physician. The state estimates that about 40 percent, or 16,833, of the 42,254 SSI disabled beneficiaries were enrolled in managed care. Of these individuals, 1,776 were enrolled in the HMOs; the other 15,057 were enrolled in the PCP program.

Managed care enrollment is mandatory for most categories of Medicaid clients in urban counties and those rural counties that have managed care providers; in the twelve rural counties where there are no managed care providers, managed care enrollment is voluntary. Nevertheless, clients living in these counties are encouraged to enroll with managed care providers and receive their health care in other counties. Clients in two Medicaid eligibility categories, persons in foster care and persons who are dually eligible for Medicare and Medicaid benefits, are exempt from mandatory managed care; however, their enrollment is encouraged. No person in any Medicaid eligibility category is excluded from managed care enrollment.

Colorado's HMO and PCP programs operate under 1915b federal freedom of choice waivers. The state also has 2176 home and community based services waiver programs for persons who are elderly, blind, MR/DD and physically disabled. The state had a waiver for persons with chronic mental illness until 1985, when the federal government terminated all mental health waiver programs. These waivers were discontinued because the government claimed that the individuals being served in these waivers would not have qualified for

institutional care, and thus, rather than serving a diversionary purpose, the waiver was widening the net and expanding the number of persons states were serving.

The Department of Health and Medical Services is the single state agency for Medicaid in Colorado. The agency is organized around a central office located in Denver, the state capital. Area offices are located throughout the state. The Department traditionally has had a Medicaid Director and three Division Directors, with an administrative services office in each division. The Department was recently reorganized into three service areas: Administrative Services, Long Term Care, and Acute and Ambulatory Services. The Medicaid Director is responsible for the overall management of the three service units and the Medicaid budget office, which is a separate division. Managed Care is a section within the Acute and Ambulatory Services unit. The Department operates with 104 full-time equivalent employees, and only 2.9 percent overhead.

II. History of Managed Care Development in Colorado

Medicaid managed care was designed in the early 1970s to address perceptions that the state was not using resources as efficiently as possible. In 1973, Rocky Mountain HMO (RMHMO) was developed on the Western Slope of the Rocky Mountains, an area with a limited number of health care providers. RMHMO capitalized on the limited competition, and quickly enrolled 30 percent of the market and obtained a Medicaid contract. RMHMO offered an innovative delivery system which was acceptable to the medical community, since the HMO model provided access for the Medicaid population and providers did not have the paperwork or billing they have in the fee-for-service Medicaid system. RMHMO's current enrollment

consists of 20 percent Medicare enrollees, 20 percent Medicaid enrollees, and 60 percent commercial enrollees.

Shortly after RMHMO became operational, San Luis Valley HMO (SLVHMO) was developed in an agricultural area in the Southeastern part of the state. The San Luis Valley's major industry is potato farming; the area's economy is depressed. San Luis Valley has a large Hispanic population, and a large percentage of the population are dependent upon Medicaid for health care. SLVHMO contracted with the state to care for Medicaid clients from the mid-1970s until December 1, 1992. At that time, the physicians and the state could not agree on capitation rates and the contract was terminated. SLVHMO clients were then transferred to fee-for-service Medicaid.

In the early 1980s, the state received a federal waiver that required all Medicaid clients within each geographic region to receive services from a single HMO. Some Medicaid clients, as well as current providers, were extremely angry, and threatened lawsuits. As a result, the state modified their plan. Instead of requiring 100 percent HMO enrollment, they maintained some freedom of choice and began the PCP program.

The PCP program was approved in 1982 and became operational in 1983. Medicaid tried to establish a statewide PCP network and has been successful in all but 12 rural counties. Any individual physician can serve as a PCP if she or he is licensed in the state, is a Medicaid provider, and agrees to abide by the rules of the program. Except for the health centers, all PCPs are enrolled as individual physicians, even if they practice in a group. Physicians of any specialty may serve as PCPs in Colorado. PCPs may also select their own enrollment limits. For instance, a physician may be treating a privately insured client who then becomes eligible

for Medicaid. If the physician is a Medicaid provider, she or he may continue to see that client and can become a PCP simply by requesting and filling out the PCP program enrollment forms. However, that provider is not required to serve any other Medicaid clients.

PCPs are responsible for providing primary care for each Medicaid client, and for making referrals for all non-emergency care. In addition, PCPs are required to arrange for 24 hour telephone coverage for clients. PCPs receive a biannual case management fee, the primary care incentive payment, for managing the care of their Medicaid clients. The PCP payment varies depending upon total number of Medicaid eligibles per month in the state. In order to determine the amount of payment, the Department divides the number of eligible months into the annual primary care incentive appropriation from the legislature. Because the appropriation is fixed annually, and the number of eligibles varies monthly, the incentive payment varies. Since the inception of the program ten years ago, the case management fee has ranged between $1.78 and $3.09 per client per month.

After the PCP program became operational, Medicaid began informing all recipients, even those in exempt categories and those in counties with no managed care providers, that they had to choose an HMO or the PCP program. The federal government forced them to curb this practice in 1985 because, while the state can encourage clients in non-mandatory geographic areas or non-mandatory eligibility categories to choose a managed care plan, they cannot dictate their enrollment.

Although the HMO program in Colorado does not exclude any category of Medicaid beneficiaries, and HMOs cannot discriminate against clients with disabilities in their enrollment processes, no special services are offered to beneficiaries in the SSI disabled categories.

Interviewees believe that people with disabilities are an afterthought in the Medicaid system, although there are some providers with disability expertise. For example, in RMHMO there are providers with expertise in serving this population.

In addition to managed care programs serving the SSI disabled population, the state has several Home and Community Based Services (HCBS) waivers providing a wide range of services to persons who are elderly, blind, MR/DD and physically disabled. Individuals in the HCBS waiver programs can receive personal care and homemaker services, as well as a variety of other services in the community depending on their level of need and functional skills. A major HCBS provider is the Atlantis Community, an Independent Living Center. Atlantis has a strong advocacy focus and recently challenged the exclusion of persons with mental illness from HCBS waivers through the courts. In this case, Atlantis wanted to provide a person with schizophrenia services through the HCBS waiver, evén though mental illness is not covered in the waiver. The Department said the individual did not meet the criteria for the waiver and denied him and Atlantis. The courts, however, ruled the person must be served through the HCBS waiver. In the past, persons with mental illness sometimes have attempted to enroll in the HCBS waiver programs, because people receive more services through HCBS than through community mental health services. Although HCBS waivers do not mandate serving this population, because of the resolution of this case, it is now unclear how many other people with mental illness will need to be served in the waiver program, and how the state will manage to serve all in need. Medicaid officials suggest that other advocacy groups for disabled clients are also active in Colorado. The Alliance for the Mentally Ill (AMI) is dominant, and, due to their influence, all state mental health dollars go to serving persons with chronic mental illness. The

state has had few complaints from disability advocacy groups specifically about managed care because interviewees report that advocates believe managed care has improved access to health care services. In addition, officials believe that disability advocacy groups are more likely to bring their complaints to the Departments of Mental Health or Mental Retardation than to Medicaid.

III. Financing and Reimbursement

Colorado's HMOs are required to provide inpatient and outpatient hospital services, physician services, lab and x-ray, prescription drugs, physical therapy, occupational therapy, speech and language therapy, substance abuse treatment, inpatient psychiatric services for persons over 65 and under 21, outpatient mental health services, care in a skilled nursing facility (SNF), durable medical equipment, day treatment, partial hospitalization and detoxification. HMOs are at full risk for all covered services. All obstetrical care is fee-for-service, and not part of the HMO benefit program because HMOs do not want to accept the risk for pregnancies.

HMO capitation rates are set annually, and are based on age, sex, and aid category. Colorado uses the following process for setting HMO capitation rates: By January 1, the Department obtains all fee-for-service claims from the previous year for services that are part of the HMO benefit program. The claims information is entered into a matrix table with age, sex and aid category on one axis, and type of service on the other axis. The total cost of the fee-for-service claims is divided by the number of member months. The Department uses 95 percent of that amount as the maximum capitation payment for each aid category, and then tries

to negotiate a lower rate. A HCFA study recently completed by Ann Arbor Actuary Associates maintained that Colorado has an effective process for setting capitation rates.

Although the majority of recipients are eligible for Medicaid through AFDC, the 17 percent of recipients who receive SSI benefits comprise a substantial proportion of Medicaid costs. The capitation rate for AFDC is considerably lower than rates for most disability categories. Although persons age 65 and olde. with disabilities (OAP-A) have a lower capitation rate than AFDC because Medicare covers most of their costs, the capitation rates of all other SSI categories are notably higher than AFDC rates. For example, while AFDC rates are approximately one and one-half times the rate for OAP-A, the rates for persons age 60 to 64 with disabilities (OAP-B) are about twice the OAP-A rate. Moreover, the rate for persons under age 60 with disabilities (AND) is approximately three times the OAP-A rate.Medicaid pays HMOs capitation rates close to what HMOs receive for commercial contracts, although interviewees considered Medicaid clients a more difficult population to care for.

Although stop-loss reinsurance is not a statutory requirement for HMOs in Colorado, the state does have strict HMO solvency requirements. To meet these requirements and protect themselves from catastrophic costs, HMOs often choose to purchase stop-loss reinsurance. The state does not provide this insurance; the HMOs purchase their own through private insurers, although the state would provide it at a comparable rate if it were requested. Another protection against insolvency for the HMOs is their risk sharing arrangement with Medicaid. Although the HMOs receive a capitated payment from the state for their Medicaid enrollees, the HMOs pay their providers on a fee-for-service basis. At the end of each year, the plan compares revenues to expenditures, and if revenues exceed expenditures, the excess is distributed among the plan

physicians. However, if the expenditures exceed revenues, the plan is at full risk for the loss. Interviewees reported that plans have most often profited from their HMO contracts.

Colorado's PCPs provide primary care services and referrals to specialists. All PCP care is fee-for service and PCPs receive a case management fee for serving Medicaid clients. In addition, the Department also requires co-payments for some services, including inpatient hospital stays, outpatient hospital visits, outpatient physician visits, psychiatry, care at a community mental health center, care at a health clinic and prescription medications. Co-payments range from 50 cents for some generic drugs to $15.00 for an inpatient hospital stay. PCP program visits require a $2.00 co-payment. The PCP is not at risk for any services used by an enrollee.

The Department believes that, overall, managed care has been cost effective, with HMOs less costly than the PCP program, and the PCP program less expensive than traditional fee-for-service. However, they do not save much money in the PCP program on clients in the AND category because these individuals have expensive, difficult to manage disorders such as diabetes, multiple sclerosis and mental illness. The overall savings from the PCP program is estimated at $2.01 per person per month, primarily from decreased emergency room utilization and increased preventive care by AFDC enrollees.

IV. Marketing and Enrollment

Enrollment in Colorado's managed care programs is mandatory for all Medicaid recipients in counties with managed care providers, except persons in foster care or those dually eligible for Medicaid and Medicare benefits. At the time of application for or redetermination

of Medicaid benefits, clients are provided a brochure about managed care and instructed to select an HMO or a PCP. In the past, selection has not been strictly enforced, and as a result, 36 percent of Medicaid beneficiaries, or 88,360 persons, have not selected a managed care provider. These clients obtain care through the traditional fee-for-service system. In order to confront this problem, the Colorado legislature passed HB-1306 in 1992 authorizing the Department to assign beneficiaries who do not select a provider to a managed care provider. The automatic assignment process was implemented in some parts of the state in April 1993.

Marketing managed care to Medicaid beneficiaries is the responsibility of the Department's Income Maintenance Technicians (IMTs). IMTs introduce clients to the managed care system during the Medicaid application process, and provide them with informational brochures explaining the benefits of managed care plans. The Department also provides a toll free PCP program information hotline. After the applicant is approved for Medicaid, she or he may ask their IMT or call the hotline worker for help with choosing a provider or to answer any questions.

Marketing procedures for the SSI disabled population are the same as those for the rest of the Medicaid population. Persons with disabilities are exempt from mandatory selection of a managed care provider only if they are dually eligible for Medicaid and Medicare. However, these dually eligible clients are encouraged to select a managed care provider. While the department makes no exceptions to mandatory managed care enrollment, they do not aggressively pursue some groups of Medicaid eligibles if they do not choose a provider, particularly pregnant woman, because obstetrical services are not included in managed care programs.

V. Provider Participation

Colorado has 1,927 fee-for-service PCPs, 24 health clinic PCP contracts, and one HMO that serve Medicaid clients in managed care. Interviewees thought there was a sufficient number of physicians to serve Medicaid clients in most areas of the state, although in some rural counties there are fewer providers and an overall physician shortage. The state has more difficulty encouraging Medicaid participation by dentists. However, other than dentists, there is little difficulty with access to specialists.

Any type of licensed Medicaid provider can serve as a PCP. Because the contracting HMOs have been IPAs, physicians can be in both the HMO and the PCP program. The Managed Care section of the Department is responsible for marketing managed care to providers. Provider recruitment is accomplished by mass mailings to all Medicaid providers once or twice each year. In addition, each Medicaid provider receives a quarterly newsletter published by the PCP program, which encourages program participation. Finally, providers are mailed PCP program enrollment packets when they receive their new Medicaid provider number.

A physician interested in becoming a PCP can request an enrollment packet at any time. The physician returns the enrollment forms to the hotline office. The information is entered into the computer and any special enrollment restrictions are noted (i.e., accepts only children, will accept a certain number of clients). Participating doctors cannot discriminate but they can set limits or state they lack expertise to serve certain types of clients; interviewees were not aware of physicians intentionally excluding certain categories of clients. Physicians are able to make changes to their enrollment status at any time by either calling or writing the PCP program hotline office. Although the PCP program has provided access for clients, interviewees believed

it may be a source of aggravation for physicians, as they are required to make referrals and take the time to coordinate care. Interviewees believe that providers prefer to work for the HMOs than join the PCP program, as the HMOs pay their physicians far more than what PCPs receive from Medicaid. The HMOs are able to pay higher fees to physicians because the plans' strong utilization control, combined with the risk sharing mechanism, has most often created a profit.

The Department recently conducted a PCP survey that indicated physicians are angry about being targeted for low rates. Interviewees stated that there are limited funds to pay PCPs after paying hospitals approximately 63 percent of their charges. Physicians are paid a range based on service rendered, but the average is about 50 percent of charges. Other than the low payment rates, however, providers appear as satisfied with managed care as they are with Medicaid in general. In addition, interviewees knew of no specific provider complaints about clients with disabilities. The Department plans to begin administering provider surveys on an annual basis.

VI. Quality of Care

Colorado uses several monitoring activities to ensure access and quality in its Medicaid managed care plans, including ongoing monitoring by the state and the Colorado Foundation for Medical Care (CFMC), a peer review organization.

Medicaid has a grievance procedure for both the HMO and the PCP program. HMOs are also required to have their own enrollee grievance systems. Any complaint is channeled first to the HMO or PCP, then to the Medicaid grievance system. Most complaints have involved pre-authorization services. However, the Department receives more questions than

complaints, and in the past two years, no complaint has become a formal grievance. Problems can usually be worked out at the hotline level or by the Section Manager.

Quality in the HMOs is monitored by the Colorado Foundation for Medical Care (CFMC). CFMC conducts on-site medical record reviews of a sample of records. For each medical record, they monitor hospital inpatient care, SNF, physician office record, ambulatory surgery record, and hospital outpatient department care. For each setting there is a set of standards against which the record is measured. For example, in physician office records, the reviewers check for legibility. They review each entry for baseline data, including vital signs, current medications, drug allergies, complaint specified, tests ordered and completed, and patient notification of test results. They also look for a specific diagnosis, patient monitoring, and compliance information. And in hospital records, they check medical stability at discharge, blood pressure, eating, discharge plan, home health services arranged, and if the patient was returned to surgery with complications or any other complications.

This CFMC review is part of the HMO contract for physicians. Physicians from hospitals and SNFs send their records to the HMO. A three percent random sample of Medicaid records are reviewed annually. They also review a three percent sample of Medicare, and complete other focused reviews if asked. However, few of the records pulled are those of clients with disabilities because most clients are eligible for Medicaid through AFDC.

Other CFMC quality assurance activities examine internal quality, determining whether the plan has the necessary components, including a Board of Directors, a physician group monitoring quality assessment, and active working committees. Peer review nurses flag problems, and give the record to a CFMC physician of the same specialty as the physician with

the problematic record. The CFMC physician is responsible for contacting the physician with the compliance problem and making suggestions for changes. For general HMO deficiencies, cases are expected to be corrected and are put through the review process again. CFMC educates the plan about their deficiencies, develops checklists for correctional plans, and has physicians available to consult with plan doctors.

CFMC's sanctioning power is that they can recommend that the Department terminate their contract with the provider, although they have never done this because they believe quality in the HMOs has generally been good. However, they have required corrective action plans with quality assurance components. Any problems the monitoring process has identified have been addressed, and physicians have been educated. Recently, in response to concerns, the HMOs improved their immunization rates and developed systems to follow newborns.

Some suggested that PCP program monitoring is not as strong as HMO monitoring. Whereas HMOs are required to have a written quality assurance plan, there are not such well-developed quality monitoring procedures in the PCP program. The CFMC reviewer suggested that monitoring would improve if the Department viewed themselves as an administrator of an IPA, and employed similar quality monitoring procedures to those CFMC uses to monitor the HMOs.

The Department administers consumer surveys for the PCP program and the HMO to fulfill quality of care and access requirements for HCFA. They recently mailed a survey to 1,600 HMO clients, and received 614 responses (38.4 percent response rate). Of the 36 percent of respondents who commented in the narrative section of the survey, only 9.2 percent made negative comments.

There are few disenrollments from managed care because of the mandatory nature of the program. Most disenrollments occur because people die or move out of state. A very small number shift from the PCP program to the HMO or from the HMO to the PCP program. Providers may be disenrolled by the State Board of Medical Examiners, by disenrolling from Medicaid, by requesting to be disenrolled from the PCP program, or if an HMO contract is not renewed. However, the HMO providers can remain PCPs or request to become PCPs and maintain their Medicaid clients if their HMO contract is not renewed because the Department invites new PCPs at any time.

VII. Utilization of Services

Colorado's HMOs are responsible for managing the service utilization of enrolled Medicaid recipients, with CFMC providing technical assistance as needed. Utilization is managed in several ways, including requiring each HMO to have a written utilization monitoring plan; CFMC review of HMO operating costs, number of eligibles, and units of service; and CFMC review of HMO case records.

In the HMOs, primary care providers are responsible for coordinating all services in the HMO benefit package. Clients are responsible for contacting the HMO before going to the hospital if they believe they need emergency care. In life-threatening emergencies, when a client goes directly to the emergency room, he or she must contact the HMO within 48 hours. One interviewee thought that the physician may not always be the best choice to coordinate care because although physicians do a credible job with medical case management, they do not always recognize signs of drug and alcohol abuse or family violence. Even if they do identify a

problem, they may not be aware of resources to direct patients to in the community. This interviewee believed that clients should have both a medical case manager and a social case manager.

In the PCP program, Medicaid is responsible for utilization control. Techniques used to control utilization are referral, prior authorization, second opinions, PCP utilization review reports, co-payments and the lock-in program. First, a signed referral form is required for all specialty or inpatient care. The referral must be in the system for payment. However, it is easy to manipulate the system and send in additional referrals once someone has a PCP provider's number. Second, prior authorization by the Department and second medical opinions are required for certain procedures. Third, PCPs receive periodic recipient utilization review reports. The PCP is expected to review this report and notify the Department of any unauthorized or non-referred care. Medicaid will not pay the bill if a client is treated by the wrong PCP.

In addition, the Department uses client co-payments as a deterrent to inappropriate utilization. The Department enforces the following co-payments for clients in the PCP program: $15.00 for each inpatient hospitalization; $3.00 for each outpatient hospital visit; $2.00 for each outpatient physician or PCP visit; $2.00 for each visit to a community mental health center or health clinic; $.50 for every 15 minutes of care by a psychiatrist; $.50 for some generic drugs; and $2.00 for other drugs. Pregnant women and children are excluded from the co-payments and there is no co-payment for emergencies. The HMOs are not allowed to charge co-payments for Medicaid clients.

Finally, there is a lock-in program for clients who overutilize services based on criteria for each service established by the Department. If a client exceeds the parameters for service utilization, he or she can be placed in the lock-in program. Clients in this program must use one physician and one pharmacy who are jointly responsible for managing all of their health care.

No referral or prior authorization is required for emergency room visits. However, as Medicaid clients are supposed to use the emergency room only in true emergencies, Medicaid will not pay for the care unless the bill is marked emergency. Some believe managed care can reduce emergency room use since access is improved. If clients have a name and number on a card, they have a place to go or a person to call in urgent situations, and are less likely to go directly to the hospital.

Some interviewees had questions about the effectiveness of Medicaid's utilization management for their managed care programs. The Department has done no overall utilization analyses, although they occasionally do studies to target high-cost clients. They are aware of the level of utilization in the PCP program since the Department receives fee-for-service claims, but have little information about the HMOs because HMOs have their own utilization review systems and receive a capitation payment. However, interviewees believe it is likely that the HMOs are doing a good job with utilization control because most years they have demonstrated a profit and the HMOs have developed some strong utilization control strategies. For example, RMHMO uses statistics to show each physician's utilization, and their plan administrator schedules individual meetings with physicians to discuss the findings. The Department would like to begin using utilization statistics similar to RMHMO's in the PCP program. They have

begun to develop utilization reports tailored to each PCP based on Medicaid claims data. Each physician can see his or her clients' utilization, and where he or she ranked in terms of other PCPs.

In addition to controlling utilization, the Department wants to promote continuity of care. Besides managed health care, the Department employs other methods to coordinate care for persons with disabilities. For example, for clients in the HCBS waiver the individual case plan is a mechanism to ensure service coordination. Working-age adults with disabilities are often case managed through HCBS, with Atlantis providing many of their support services. The state also has Targeted Case Management (TCM) for persons with MR/DD who are not in the HCBS waiver through the Department of Mental Retardation. However, there is no TCM offered for persons with mental illness. Clients with mental illness often obtain services through the community mental health centers (CMHCs). Finally, the Department has applied for a grant from the Robert Wood Johnson Foundation to administer TCM for persons with diabetes. TCM can be added to the state Medicaid plan as an optional benefit; it does not have to be offered statewide or to all categories of Medicaid eligibles.

The Department cannot provide utilization information for each of the groups of clients with different disabilities. Except for the lock-in group, the state does not target high cost clients, but does sponsor the previously mentioned categorical TCM programs for persons with disabilities.

VIII. Data

Colorado's Medicaid program does not receive person specific data for clients enrolled in HMOs. Person specific data are in the Medicaid claims system for PCP program clients. For these clients, the Department prepares periodic utilization and cost reports as needed. The Department may obtain other data from the system as needed to generate reports, for example, to prepare the recent utilization reports for each PCP.

The HMOs are not required to send the Department any data. At rate setting time, the Department and the HMO review the past year's data. All low birthweight and prenatal hospital admissions, and immunization data are reported by the HMOs for the EPSDT program. The Department wants to begin to require more data collection and reporting.

IX. Current and Future Issues

The Department plans to expand managed care through three different initiatives. First, they would like to increase HMO contracting. Second, they plan to begin to enforce mandatory assignment to managed care. Finally, they intend to develop managed care programs that capitate for specific services. Moreover, the Department plans to increase the frequency of the PCP program incentive payment from semi-annually to quarterly. They expect that more frequent payment will be a positive reinforcer for the time and effort of case management. Each initiative must be considered in light of the need for Medicaid reform, as costs are increasing at a rate of 20 percent per year, and the Department must cut $150 million from the $1.3 billion 1994 budget.

As one method of dealing with budget constraints, Colorado plans to implement Colorado Care, their state health reform initiative. The Department has received a $500,000 grant from the Robert Wood Johnson Foundation and another $100,000 from a Colorado trust to implement this program. Although Colorado Care is still in the planning stage, it appears that the health care system for those under age 65 will be reformed, with all funding sources for this population combined into one state pool. A managed competition system will be set up with between eight and fifteen providers offering a set of uniform benefits on a competitive bid basis. Providers would receive a fixed dollar amount and be at full risk.

Although the Department is trying to increase HMO contracting, in the past, too few commercial HMOs have been willing to contract with Medicaid, and it is unclear how many new HMO contracts will be needed to serve all clients, particularly with mandatory assignment. The Department is working on other solutions, including contracting with more PCPs. However, interviewees suggested that a more structured system than the current PCP program model would be preferred to better control costs and utilization, and the Department has considered developing a partially capitated PCP program.

The Department is also contemplating a prepaid mental health plan, similar to Utah's, with a package of mental health services provided to all Medicaid clients by specific mental health providers. This program would be developed jointly with the Division of Mental Health. The plan is to apply to HCFA for a waiver and put the program out for bid if the waiver application is accepted. Colorado would like to contract with community mental health centers as well as other providers under a framework of managed competition. Interviewees expect that a prepaid mental health program will increase access to care, ensure the provision of high quality

services, and decrease the cost of treating mental illness. In addition, currently all state mental health dollars are spent on clients with chronic mental illness; the prepaid mental health plan would allow some services to be provided for other populations in need mental health treatment as well. Colorado has several other health care concerns they plan to address. First, there is the problem of limited access to care in rural areas. The Department continues to encourage increased physician participation in managed care, and is working with medical societies and provider groups to develop innovative managed care delivery systems for Medicaid clients living in rural areas.

Second, clients need to be better educated. The state is developing an educational program for clients to address the appropriate use of the health care system. By teaching clients to properly access and utilize health care, the Department hopes to reduce costs of inappropriate care and overutilization.

Third, while the Department plans to begin paying for personal care in situations where they deem it is warranted, they are concerned that there may be conflict between Medicaid and advocacy groups because personal care will not be a routine Medicaid benefit. Thus, some individuals who believe access to this benefit is essential will not receive it because the Department cannot afford to provide personal care on a routine basis.

Finally, the state is dealing with the issues of coordinating care, particularly for high cost clients, including those with disabilities. Interviewees thought the state needs to better define disability and decide how to best provide and coordinate services for this population, as well as determine whether it is necessary to use a single case manager for both medical and support services. There is a concern about what will happen with Colorado Care and persons with

disabilities, because while interviewees expressed comfort with integrating special populations in managed care, and Colorado Care is supposed to have universal access, it is possible that when commercial HMOs realize the costs of serving the elderly and clients with disabilities, they will prefer not to serve them in mainstream managed care. Thus, clients with disabilities may have to be carved out and excluded from the universal access system.

X. Summary and Lessons

State officials in Colorado believe that Medicaid managed care programs can be used to increase access to and quality of services for Medicaid recipients, and contain costs for the state. They believe that managed care programs are appropriate for almost all categories of Medicaid beneficiaries, and have developed a system that mandates enrollment. Medicaid officials also believe that expanding managed care by increasing the number of contracting HMOs and developing plans that capitate specific service packages, will further increase access and control costs. Although interviewees gave no specific dollar amounts, they reported that managed care has been cost-effective. However, for recipients with disabilities, the cost savings were described as less than for the populations. Nonetheless, the Department believes these clients can be served most adequately and efficiently in managed care and does not support carving out certain eligibility categories or special populations.

Interviewees asserted that other states need to educate providers and themselves about clients with disabilities. They believe that providers need greater awareness of who these clients are and what their needs are. Interviewees also thought that after assessing the needs of clients in the SSI disabled population, states would recognize that this group can be adequately served

in mainstream managed care. Moreover, interviewees suggested that states reconsider how case management is executed. Because of the need to be cognizant of many non-medical issues, it is possible that one person to manage both medical and non-medical services may not be the most effective method of service coordination. It was proposed that states consider a new model, using a physician to manage medical service and a social worker from an agency outside the health care system coordinate support services, as a viable option.

Information Resources

Interviewees

Colorado Department of Health and Medical Services

Donna Allen, Primary Care Physician Program Coordinator

Donna Marshall, Manager, Managed Care Section

David West, Medicaid Director

Colorado Foundation for Medical Care

Michele Workman, Special Projects Manager

Documents

Managed Care Beneficiary Marketing Materials

Provider Marketing Materials

PCP Program Enrollment Forms

PCP Program Physician Protocols

Medicaid Appeal Process Information

Colorado Foundation for Medical Care's Quality Assurance Findings

1990-1991 HMO Consumer Survey

HMO Consumer Survey Results

Freedom of Choice Waiver Renewal Application

Colorado Department of Health and Medical Services Organizational Chart

HMO Program Description

Model HMO Contract

Medicaid HMO/PHP Memorandum of Understanding

Evaluation of Freedom of Choice Waiver

Medicaid Managed Care Programs for the SSI-Disabled Population
The Case of Florida

I. Brief Overview of the State

Thirteen Florida HMO's receive a capitated payment from the state to provide comprehensive health services to enrolled Medicaid recipients. These plans have 30 HMO sites in eleven counties, most of which are concentrated in the southern tip of Florida. Florida has also developed a Primary Care Case Management Program, entitled Medi-Pass, that currently operates in District Six, the greater Tampa/St. Petersburg area. Services provided through the Medi-Pass program are reimbursed on a fee-for-service basis, and participating case managers receive three dollars per member per month to case manage recipient care plans.

Florida has entitled 1,388,801 recipients to receive Medicaid benefits, of which 365,490 are eligible through the Supplemental Security Income (SSI) program. The number of individuals who become eligible for Medicaid benefits is increasing by 30 to 40 percent each year. Of those receiving SSI Medicaid benefits, about 43% receive no Medicare benefits, 12% receive Medicare Part B benefits, and about 44% receive both Medicare Parts A and B benefits. Of the total number of Medicaid recipients, 870,175 (637,938 AFDC and 232,237 SSI) live in counties where HMO's are offered. A total of 199,142 AFDC and 14,704 SSI recipients are enrolled in these HMO's. Thus four percent of all Florida SSI recipients, and about six percent of SSI recipients residing in HMO counties are enrolled in HMO's. At the time of the site visit, only AFDC recipients were enrolled in the Medi-Pass program.

There is an uneven distribution of SSI enrollees among the prepaid health plans. About 55%, or 8116, recipients are enrolled in one health plan, and two other health plans each enroll 2133 and 2632 respectively, or 15% and 18% of the total enrolled SSI recipients. Thus, 88% of all enrolled SSI recipients were enrolled in three of the thirteen plans. The remaining 12% were distributed among six plans, with enrollments ranging from 10 to 513, while three plans enrolled zero SSI recipients.

State Medicaid administrators could not tell us the total number of prepaid health plans operating in the state, because the number frequently changes. However, they suggested that they have received a "dozen" applications from new providers this year, and expect to have three or four of these new plans begin enrollment soon. Florida has a long history with prepaid health plans, particularly Medicare TEFRA HMO's and risk contracts.

Florida's Medicaid program operates three home and community-based waiver programs. The one serving Aged/Disabled provides services to 11,300 recipients; the Developmental services program provides services to 2631 recipients; and the AIDS waiver program serves 1300 recipients.

Florida's Medicaid program is part of the Department of Health and Rehabilitative Services, and is managed by an Assistant Secretary for Medicaid. The Medicaid Department has existed since 1975, and employs about 40,000 people. The Department is organized around a central office located in the state capital in the northern part of the state. The Central Office primarily sets policy and pays bills. Fifteen district offices are service offices, located throughout the state. At least one interviewee alluded to tension between the central and district office staff, attributable to the differing functions of the two types of offices, the rural/urban

differences within the state and the cultural variation within Florida, particularly between the North and the South. Medicaid's managed care programs are planned and implemented in a Managed Care Office, that was organized four years ago, within the Central Office.

II. History of Managed Care Development in Florida

The Florida legislature first authorized the state to enter into contracts with county health departments to demonstrate pre-paid managed care systems for Medicaid recipients in 1979. The Florida Department of Health and Rehabilitative Services established the first Medicaid pre-paid demonstration project in 1981 in Palm Beach County. Subsequently, the state was selected in 1982 to serve as a site for the HCFA Medicaid competition demonstrations. For purposes of the demonstration, Florida proposed that four different alternative delivery modules be developed based, in varying combinations, on the principles of pre-paid capitation, case management and competition. Unfortunately, there were numerous problems in the implementation of the four modules. For example, the module based on vouchers to purchase insurance never was implemented because insurers were not interested in participating in the demonstration. The module based on case management for recipients who overutilize services was quickly converted from a demonstration to a state program. The remaining two modules were partially implemented: Medicaid enrollment in existing pre-paid health plans, and a prepaid health plan for frail elders. However, neither of these modules could serve as a model for future development. The pre-paid health plan module was to be based on competitive bidding, but there were not enough qualified bidders to make this successful. The frail elder option was only implemented at one site, and enrolled few beneficiaries.

The competition demonstration experience prompted Florida to change its process for selecting pre-paid plans to participate in the Medicaid managed care program. Beginning in 1985, Florida began to contract with any pre-paid health plan that meets federal and state financial and quality assurance requirements. Both AFDC and SSI eligible recipients are enrolled in the pre-paid health plans.

Florida began enrolling AFDC recipients in their PCCM, Medi-Pass, in 1991. In the Medi-Pass counties, AFDC recipients must choose to enroll in either the PCCM or a pre-paid health plan. The state plans to further develop the PCCM throughout the state for AFDC recipients. Florida recently received permission to include SSI recipients in the program as well. Florida operates the Medi-Pass program under a 1915(b) waiver. Florida's goal is to use the Medi-Pass program, along with expanded pre-paid health plans, to enroll all Medicaid recipients in managed health plans. Officials hope the expanded program will ensure access and manage costs for this population.

Florida began to include people with disabilities in its managed care programs early on. However, the state knows little about the experience of disabled recipients in these plans, and has heard little from advocates about their participation. Although consumer advocacy groups in Florida appear not to be that strong, Medicaid officials still suggested that legislators are "afraid to make them mad".

III. Financing and Reimbursement

Florida's pre-paid health plans are required to provide inpatient and outpatient hospital services, physician services, lab and x-ray, prescription drugs, EPSDT, therapy services, home

health care and durable medical equipment. Although plans may not specify limits on outpatient hospital days or prescription drugs, inpatient risk is limited to 45 days. On an optional basis, plans may also provide hearing, vision, dental, family planning, transportation or nursing home care.

Capitation rates are calculated for this service package. Rates are calculated for several categories in each county: AFDC, SSI/No Medicare, SSI/Medicare A only, SSI/Medicare A and B. There is no weighing for age or gender. To calculate capitation rates, the state uses paid claims for the most recent year ending on June 30 for a comparison group of Medicaid recipients. These claims data typically have a six to twelve month lag time. The state first computes a utilization rate for each service included in the capitation, and then computes a cost per unit of service. The costs for each type of service are summed to arrive at the base capitation amount. The state sets the capitation rate at 95 percent of this amount. State Medicaid officials are concerned about the accuracy of this method. As more recipients enroll in managed care plans, the residual population on which to base the capitation rates may not be representative of the enrolled population. One interviewee suggested that as a result "our HMO's are not losing their shirts". Moreover, program officials have inadequate understanding about the experience of the SSI recipients enrolled in managed care plans, and whether the capitation rates are appropriate for this group.

Since the competition demonstration, Florida has given pre-paid health plans the option of including nursing home services in their capitation rate. Florida's "frail elderly option" calls for the development of capitation rates based on both the traditional list of primary care services as well as nursing home admissions until the end of the contract year. Although the frail elderly

option is available to all SSI capitation groups covered by pre-paid health plans, only one plan has actually implemented the option. Medicaid officials expressed concern that the capitation rate paid to this plan was "too high" (it ranges from $11,000 to $16,000 per year).

Medi-Pass is a non-capitated primary care case management program. Under this program, primary care physicians receive fee-for-service reimbursement and a three dollar per member per month case management fee to manage the care of enrolled recipients. Although the results of an ongoing Medi-Pass evaluation have not yet been released, Medicaid officials expect to see savings on the order of 17-22 percent. Policymakers plan to expand the Medi-Pass program to the entire state. If they are able to do this, all recipients will be enrolled in managed care plans. The capitation rates for the pre-paid health plans would then be calculated based on the recipient population enrolled in Medi-Pass. Medicaid officials hope that capitation rates based on another managed care population will drive down the rates for the HMO program. Policymakers hope that total savings attributable to managing the care received by Medicaid recipients will then be greater than the current five percent savings. Program officials suggested they would be willing to share program savings with providers in the form of increased provider payment rates.

IV. Marketing

Enrollment in Florida's Medicaid managed care plans is voluntary and marketing to potential enrollees is the responsibility of the pre-paid managed care plans. However, the Department of Health and Rehabilitative Services does support marketing efforts by periodically distributing generic information about managed care as well as specific information about

particular plans to Medicaid recipients in monthly mailings to beneficiaries. The Department also has allowed marketing representatives to use space in the AFDC offices to recruit enrollees. The plans are also allowed to offer limited expanded benefits to encourage enrollment, such as some dental services and over-the-counter drug allowance. Plans sometimes sponsor health fairs in housing projects or shopping centers. Marketing representatives have been prohibited until recently from using door-to-door marketing techniques. The Department does prohibits plans from distributing marketing materials directly to recipients through the mail.

Florida believes these marketing procedures have worked well for them. As more plans participate in the program, there has been an increase in the competition among plans. Marketing policies and procedures, however, may change as the state moves to a mandatory choice system. It is unclear how the state will expand the program in the rural areas of the state, however.

Interviewees suggested that plans have been more willing to enroll the AFDC population than the SSI population. Although plans have not "actively avoided" the SSI population, their marketing techniques are more likely to target the AFDC population. For example, SSI recipients do not receive their food stamps at area offices, but rather through the mail. They are thus less likely to encounter marketing representatives. Moreover, interviewees suggested that SSI recipients are more likely to have their own providers, and thus be less likely to be interested in establishing a new provider relationship. There is anecdotal evidence, however, that plans may not encourage the enrollment of SSI recipients because of the risk they represent.

Florida does survey enrollees who disenroll from managed care plans to determine the reasons for their disenrollment. Although they have not examined survey responses from SSI

recipients to these surveys separately from AFDC recipients, the usual reasons for disenrollment include that clients did not like the provider, or they misunderstood their benefits. Interviewees perceived SSI recipients to be stable enrollees who do not usually disenroll. At least one respondent suggested that these clients are knowledgeable about the health care system and more demanding than AFDC recipients. Several years ago, Florida implemented a survey about client satisfaction with the managed care program. Results showed recipients were generally happy with the programs; they plan to repeat the survey this year.

At the time of the site visit, SSI recipients could only enroll in the pre-paid managed care plans. However, the state recently received approval to enroll the SSI population in the Medi-Pass program. This program will likely be the means by which the state increases the size of its managed care program statewide. Currently, AFDC recipients are enrolled in the Medi-Pass after their name appears on a monthly eligibility report. This report includes information including client name, zip code, date of birth, Medicaid number and family membership. A client on this eligibility list is sent a letter saying that he or she will be enrolled with a specific doctor. The client has ten days to telephone the department to change his or her physician assignment. Each month, about ten percent of beneficiaries request a provider change.

V. Provider Participation

As described previously, thirteen Florida HMO's receive a capitated payment from the state to provide comprehensive health services to Medicaid recipients. Most SSI recipients that participate in managed care in the state are enrolled in a limited number of these plans. There are a number of other plans in the state that have expressed interest in participating in Medicaid

managed care, and interviewees anticipate that three or four new HMO's will begin enrollment this year. However, recently, some HMO's have also stopped serving the SSI population. Interviewees suggested plans have followed this course of action after experiencing some high cost cases.

Provider participation issues are more important with regard to the Medi-Pass program. About 54,000 Florida physicians are enrolled Medicaid providers. A little over 400 physicians participate in Medi-Pass. Medicaid recruits only primary care physicians to participate in Medi-Pass. About a third of these are family practice physicians, and one-quarter are pediatricians. The remainder are internists, general practitioners, gynecologists, public health service physicians, and federally qualified health centers. These physicians are primary care gatekeepers for most medical services. However, obstetrical, mental health, vision and hearing services are not included in the Medi-Pass program. The Department excluded obstetrics because it was concerned that requiring physicians to refer for obstetrical services would be a disincentive for primary care physician participation.

Florida is enrolling SSI recipients in the Medi-Pass program on an experimental basis. A concern raised by interviewees is the ability of SSI recipients to access needed specialty services while enrolled in Medi-Pass. Many SSI recipients have complex problems, and policymakers are concerned that these problems should not be managed by a primary care physician. As an example of the way the Department plans to address this concern, interviewers said that SSI clients enrolled in Medi-Pass will be free to designate the provider from whom they would like to receive mental health services. The primary care physician will thus not be the referral agent for mental health services. However, the Department examined participating

provider lists to determine if SSI recipients would have sufficient access to the program. Results showed that the same providers serve both AFDC and SSI clients. This suggests that SSI recipients should be able to be linked to a provider.

VI. Quality of Care

The quality of the care delivered in Florida's Medicaid managed care plans is monitored and controlled in several ways. First, the Department will only contract with providers that are appropriately licensed and certified. Second, a contract manager is appointed to monitor the delivery of services at each HMO and to give routine feedback to each provider. These managers monitor appointment availability, staffing levels, hours of operation, disenrollment rates, and grievances filed. HMO's are visited quarterly to monitor these items as well as other structural factors such as wheel chair accessibility, bilingual staff availability and 24-hour access. Different items are measured each quarter, along with follow-up of items investigated the previous quarter. Moreover, a sample of medical records is reviewed annually.

Pre-paid health plans are required to have an enrollee grievance system. In addition, the plan is expected to monitor and keep a record of informal complaints. Interviewees report that there are very few enrollee grievances in general. When these do occur, district service officers address the complaints. Complaints are usually not about the quality of medical care, but rather about administrative issues such as plan policies or denial of coverage. Interviewees could not recall a specific grievance coming from an SSI enrollee.

The Department uses a facilitative approach to control quality of care, preferring not to be bureaucratic in their monitoring. When they encounter a problem, they expect the provider to submit a corrective action plan. They also depend on their district offices to have a "sense of the providers".

VI. Utilization of Services

Florida's pre-paid health plans are responsible for managing the utilization of enrolled Medicaid recipients. The Department provides technical assistance in this area to the plans if necessary, and reviews their utilization control processes, but is not involved in implementing these policies. Interviewees believed that the plans adequately control utilization and they have never had a contract failure in this area. Florida's Medicaid program is unable to track the claims payment history of these clients, however, because the Department keeps a record of only the capitation payment.

In the Medi-Pass program, primary care providers must approve referrals to out of plan providers. They have established systems that reject claims that have not been approved by a recipient's case manager.

The Department cannot provide utilization information for each of the groups of clients with different types of disabilities. They do monitor certain types of utilization within the pre-paid health plans by eligibility group, however. The Department's data show that SSI recipients use services at rates that are over three times the rates of AFDC recipients for inpatient and outpatient services. SSI clients have utilization rates that are twice that for AFDC recipients for emergency room utilization and physician office visits.

VII. Data

Florida's Medicaid program does not receive person specific data for clients enrolled in pre-paid health plans. The plans do provide the state with aggregate information including number of SSI and AFDC recipients per month and service utilization by the following service categories: inpatient hospital days, outpatient days, emergency room visits, physician office visits, prescriptions, and number of enrollee months. The utilization information is annualized per 1000 members per month.

Data for the Medi-Pass program include data typically gathered for a traditional Medicaid eligibility and claims processing system: eligibility, demographic, claims history information. In addition, the state maintains utilization profiles on individual physicians to compare their performance with practice norms. Quarterly physician utilization reports are produced. If physicians are outliers in two or more areas, they are given the opportunity to justify their performance. If this experience continues for more than two quarters, physicians are then required to justify their performance.

VIII. Current and Future Issues

The Department is planning to extend its continuum of managed care options by developing a capitated mental health plan in the same district in which Medi-Pass operates. Historically, community mental health services have not been included in their managed care programs. Under the terms of the waiver for the proposed program, the Department will identify one provider to serve as the managed care plan for people using mental health services. This approach addresses provider concerns about adverse selection, and the effects of

competition among small providers. Under this program, the following services will be provided under a full risk 45 day stop loss contract: inpatient, outpatient, psychiatry, community mental health under the Rehabilitation option, targeted case management, and 15 psychotropics, including clozaril. Because this will be a demonstration, the Department expects to have a settlement with providers for certain reimbursable services, because they have little prior experience in reimbursing some of these services.

To develop the capitation rate for this program, the Department is using data on 7360 mental health service users in the district. There are 116,583 Medicaid recipients in this area of the state. Of the mental health users they have identified, 3820 are AFDC recipients and 3540 are eligible by virtue of SSI. They are in the process of developing the rate structure for this program. They have been delayed by the finding that one county in the area has an exceptionally high inpatient utilization rate. The Department is investigating this finding before completing the rates.

The Department of Mental Health is working with Medicaid on developing the mental health program. Interviewees suggested that Mental Health staff are not happy with this program, believing that it is a medical model, and they would prefer a rehabilitative model. However, the Departments have worked together to identify provider contract criteria.

Florida is also considering developing capitated programs for the MR/DD population. Officials suggested they would like to capitate the entire group of MR/DD recipients. They believe this approach would allow them to create community based care plans for clients who now reside in institutions. The State Medicaid Department estimates savings would result from this approach, even though it would cost about $15,000 per client. Other state departments are

not necessarily in favor of this approach, favoring further expansion of the home and community based waiver instead. However, expansion of the waiver would require new state dollars, and the state has experienced budget reductions in recent years. Therefore, Medicaid officials believe the managed care option would be a more viable alternative.

Interviewees expressed uncertainty about how to integrate special populations into their managed care programs. Florida has had experience with this issue in its Children's Medical Service program. The program has not functioned well within the Medi-Pass program, primarily because issues have been raised about who should be the primary care provider for children with special needs, and who should be managing the complex care needs of these children.

It was unclear to interviewees whether generic managed care programs can meet the needs of all populations. All interviewees believed that programs should be tailored to meet the needs of special populations. Some thought the state should develop special managed care programs specifically to meet the needs of people with disabilities. Moreover, officials expressed their concern that providers be paid appropriately for the services they manage for these populations. However, not all interviewees believed that providers should absorb the risk for these populations. Moreover, one interviewee expressed concern about requiring managed care programs for people who are older or have disabilities. The concern expressed is that in these instances, in the rush to implement the program, enrollee needs might not be adequately planned for and met. It is critical that these issues be addressed in order to assure access to services for beneficiaries with disabilities.

IX. Summary and Lessons

Florida has had a fairly long history of developing managed care programs. State officials believe that Medicaid managed care programs can be used to increase access to services for Medicaid recipients, and maintain costs for the state. However, the state has limited evidence that can be used to support these claims, particularly with regard to the SSI disabled population. Relatively few SSI disabled recipients have voluntarily enrolled in Florida's pre-paid managed care plans, and the state knows little about the experience of recipients who have been enrolled. Moreover, it has not yet begun to enroll SSI disabled recipients in its Medi-Pass primary care case management program.

Medicaid officials believe, however, that further development of managed care plans, particularly special plans for people with disabilities will give the state more information to refine its programs. Therefore, it is developing specialized programs for recipients who use mental health services and those with MR/DD. In addition, the state is planning to expand its managed care program statewide, using both pre-paid health plan and the Medi-Pass models. State officials suggested that the primary reason they are expanding managed care plans is to improve access to services for Medicaid recipients. However, officials suggested they do not know enough about biased selection issues to determine the true costs of their managed care plans.

Medicaid Managed Care Programs for the SSI-Disabled Population
The Case of Kansas

I. Brief Overview of State

Kansas' Medicaid recipients residing in seven of the state's 105 counties have access to one managed health care program, the Primary Care Network (PCN) program. Most Medicaid recipients residing in the seven counties in which this mandatory Primary Care Case Management (PCCM) program is located must choose a primary care physician from the PCN pool of participating providers. PCN providers are reimbursed on a fee-for-service basis, and receive two dollars per member per month to case manage recipient care plans.

Participating providers are responsible for providing, coordinating, or authorizing all Medicaid covered services with the exception of emergency services and services exempt from the PCN referral requirement, including community mental health centers, HCBS screening, immunizations, Indian Health facility, newborn home visits, prenatal health promotion and risk reduction, family planning, dental, podiatry, sexually transmitted disease, vision, chiropractic, nursing home and ICF/MR services. Physicians must also provide or arrange for care 24 hours a day, 7 days a week.

Interviewees reported that the Primary Care Network program engages 371 primary care physicians, and has approximately 60,000 enrollees assigned to physician case managers. The only exclusions from participation in the PCN program are foster care/adoption support children, Qualified Medicare beneficiaries (QMBs), QMBs and Medicaid eligibles (Q&M), Adult Care Home residents, residents in State institutions, and Tuberculosis Program participants.

Kansas entitles 168,056 individuals to receive Medicaid benefits, as reflected in data reported for the month of July 1992. Of the total number of Medicaid recipients, 88,131 individuals are eligible through AFDC related categories, and 20,677 individuals are eligible through the Supplemental Security Income (SSI) disabled category. An additional 1,823 disabled individuals are eligible through Kansas' Medically Needy program. These persons meet SSI disability criteria, but not SSI income criteria, and are therefore ineligible for cash assistance from the SSI program. The remaining Medicaid recipients are eligible through a variety of other categories. A total of 82,731 (49,266 AFDC and 10,573 SSI) eligibles live in PCN counties. Thus, slightly more than half of both the AFDC and SSI disabled eligibles in Kansas reside in counties where the Primary Care Network program is located.

The Division of Medical Services, a subdivision of the State Department of Social and Rehabilitative Services (SRS), oversees the state's Medicaid program. The Division is organized around a central office located in the state capitol in the northeastern part of the state. The Central Office employs approximately 35 people. Local SRS offices are service offices, situated throughout the state.

The Department of Social and Rehabilitative Services contracts with Electronic Data Systems (EDS), a fiscal agent operating in 18 states, for Medicaid claims processing. EDS has had a long relationship with Kansas' Medicaid Department. Beginning in 1978, EDS has won three 5 year contracts, with additional contract extensions. The current contract with EDS is approximately $11 million. Interviewees noted that EDS has more responsibilities than many other states' fiscal agents. For instance, the state also contracts with EDS for provider recruitment, provider training, provider and recipient relations, medical assessments, research

support, and data system operations. EDS employs about 195 people, including 10-12 technical staff and 30-35 nurses. The remaining EDS staff work in provider and recipient relations.

Kansas' Medicaid program operates four Home and Community-Based Services (HCBS) Waiver programs. The four HCBS programs in Kansas serve nursing home residents, technology-dependent children, persons with head injuries, and persons with mental retardation/developmental disabilities (MR/DD). The Primary Care Network program also functions as a Medicaid waiver program. The state demonstrated evidence of potential cost savings with this PCCM model and received a 1915(b) waiver to enable the PCN to operate as a mandatory managed care program within certain geographic areas of the state. The PCN and HCBS waivers are completely separate entities, and eligible individuals can be served under both programs.

II. History of Managed Care Development in the State

Kansas' investment in Medicaid managed care development began in 1982, when a committee composed of representatives from Kansas' Department of Social and Rehabilitative Services, provider groups, and hospitals was formed to investigate feasible managed care approaches for the state. At the time, the state had few commercial HMOs and providers were not receptive to capitated models of managed care. Interviewees reported that physicians wanted to retain both the fee-for-service system and their control over it. Consequently, the committee wanted a managed care model that would "sell" to physicians. They decided upon a model similar to the Physician Sponsor Plan (PSP) implemented in Michigan in 1982.

The Primary Care Network program was established in February 1984, by the Kansas Department of Social and Rehabilitation Services under a 1915(b) Medicaid waiver of statewideness and freedom of choice. Kansas was one of the first states to implement a managed care model using this type of waiver. The PCN program started as a demonstration project in three counties: Sedgwick, Saline, and Ottawa. However, the project failed to achieve substantial savings in the rural county, Ottawa. Interviewees believed that Ottawa's lack of success was due to its limited supply of primary care physicians. PCN clients in rural areas had little choice of providers, and therefore utilization rates and access were not significantly affected by the program. Subsequently, at the time of the first waiver renewal in 1986, Ottawa County was dropped from the program, and five additional urban counties--Douglas, Johnson, Leavenworth, Shawnee, and Wyandotte--were added to the PCN program. Thus, only seven counties, which contain approximately 50% of the state's population, are included in the PCN program.

The primary objectives of the Primary Care Network program are: to improve access to primary care; to contain Medicaid costs without reducing medically necessary services; to reduce overutilization of services, especially nonurgent use of hospital emergency rooms; and to increase physician involvement in the Medicaid program. Medicaid officials emphasized increased access as the most important goal of the program.

The waiver covers AFDC, SSI, and General Assistance (GA) eligible recipients, as well as several other Medicaid eligible groups. SSI recipients were included in the program because of their access problems. The first PCN waiver also covered disabled nursing home residents. The state later found that the PCN program had little effect on the practice patterns of providers

serving nursing home residents. The nursing home population was therefore dropped from the program in 1986.

Medicare recipients and foster children have been excluded from the beginning of the program. Interviewees explained that foster children often use their parent's providers, and their foster parents may not have Medicaid coverage. The federally-funded family planning services have always been exempt from the PCN's referral requirement. Some exceptions have also been made for disabled individuals or for services targeted to persons with disabilities. For example, one Community Mental Health Center (CMHC) group lobbied the Department for exempt status, arguing that mental health services were already case managed. Consequently, referrals have never been required for services at CMHCs. The first PCN waiver allowed adults with MR/DD to continue care with their pediatrician case managers. Another exception was made for the Special Health Services (SHS) program for children with special health care needs. Control over specialty referrals was granted to staff at the SHS program who were concerned about disruption of referral patterns.

Although Kansas' SSI disabled population has been included in the Primary Care Network since its inception, the state has minimal information about the experiences of disabled recipients in the program, and has heard little from advocates about their participation. Some anecdotal information exists about access problems for SSI disabled recipients in the beginning of the program, perhaps due to start-up problems. One interviewee mentioned that some MR/DD clients are currently without good primary care services. In general, however, interviewees believe there are no special issues for the SSI disabled population concerning the PCN.

Advocacy groups in Kansas have focused more on HCBS services and nursing home services, than on primary care issues. Thus, most of the advocacy is for the MR/DD population and the physically disabled. There is no HCBS waiver for persons with mental illness. Two years ago the HCBS program was brought under the Medicaid program, and the state's contact with disability advocates has increased.

Although Kansas still has many Intermediate Care Facilities for the Mentally Retarded (ICF-MRs), the overall trend is toward restricting access to institutional beds for the MR/DD population and the physically disabled population. Interviewees suggested that community-based care for individuals served by the nursing home HCBS waiver may be just as expensive as institutional care, and that the cost-effectiveness of community care could become a larger issue in the future. However, Medicaid officials also emphasized that cost-effectiveness may not be the most important goal of community-based programs.

III. Financing and Reimbursement

The Primary Care Network program reimburses physicians for the medical services they provide on a fee-for-service basis. In addition, providers receive a monthly $2.00 patient management fee per enrollee for their coordination role on behalf of the Medicaid clients assigned to their care. The maximum case management fee payment per provider is $36,000 per year. The amount of the monthly case management fee was modeled after Michigan's PCCM fee, and was thus originally set at three dollars. However, the fee was reduced to two dollars in 1991 in an effort to cut administrative program costs.

Interviewees reported that some providers find the case management fee too low, or would prefer higher overall physician fees and no case management fee at all. However, administrators believe the case management fee is not a major issue of concern for providers. They are not certain the case management fee serves as much of an incentive for physicians. The state has not considered using enhanced payments instead of case management fees.

Medicaid reimbursement rates in Kansas are low. At this stage, however, the state is not recommending any Medicaid rate increases. They would like to assess providers on health care in order to levy funds for rate increases. However, Kansas' powerful provider lobby has defeated any chance for the tax with the state legislature.

Cost-benefit analyses of the PCN program have been conducted and HCFA has judged the program to be cost-effective. However, Medicaid officials question HCFA's cost-efficiency methodology for two reasons. First, the methodology requires comparisons with the base year(s) of the waiver. However, the base year for the PCN waiver was more than ten years ago, 1982-1984. Since that time, Medicaid policy changes have been made, including, for example, the diagnostic related group payment (DRG) system and changes in Medicaid eligibility. Interviewees expressed other reservations about the study design, including the definition of the non-PCN comparison group. Kansas has no current plans to expand the PCN program statewide due to: (1) earlier findings showing the program's limited success in rural areas with few providers and (2) a lack of clarity among state policymakers about the effectiveness of the current program.

IV. Marketing to Enrollees

Enrollment in the Primary Care Network program is mandatory in participating counties. Consequently, there is little marketing done for this managed care program. Information about mandatory enrollment in the PCN program is provided to Medicaid applicants in PCN counties when they apply for benefits at their local SRS office. At the initial interview, recipients are given a brochure about the PCN program, and a list of participating providers from which to choose a physician case manager. Recipients are responsible for notifying the state of their choice of provider. Family members are allowed to select different providers. Local SRS office workers select primary care physicians for recipients who do not choose providers themselves, and notify the individual of their enrollment.

Recipient assignment, however, depends on the availability of providers, and does not occur until Medicaid eligibility is established. A Medicaid card indicating PCN enrollment and the assigned provider is issued within 60 days of approval of assistance. Until receiving the Medicaid card, recipients may continue to see other physicians. Recipients may change providers if they are dissatisfied with their chosen or assigned provider. Physicians are also allowed to request that a client be dropped from his or her caseload.

Medicaid eligibility determination for the SSI disabled population presents few problems for the state. Individuals who are determined eligible for SSI benefits are automatically eligible for Medicaid benefits. SSI recipients are the only population that does not need yearly eligibility reviews. One interviewee noted that "social workers do not have to pick up the file again until the client dies".

V. Provider Participation

EDS is responsible for provider recruitment, provider training, and provider relations. Recruiting of providers for the PCN program starts when a physician is enrolled as a Medicaid provider. About 19,000 Kansas physicians are enrolled Medicaid providers, and approximately 2000 Medicaid providers serve in PCN counties. Physicians are determined eligible for the PCN if they meet county and specialty criteria. Providers recruited by EDS to serve as physician case managers include physicians in general practice, family practice, internal medicine, obstetrics and gynecology, or pediatrics.

An initial mailing is sent to eligible providers which includes: (1) a letter inviting the physician to enroll as a participating PCN provider, and (2) a promotional flyer about the program. Physicians who respond to the initial mailing are sent a PCN contract and additional PCN information. A second flyer, described by one interviewee as a "beg-o-gram", is mailed to physicians who do not respond within 30 days of the initial mailing. Physicians must inform their current Medicaid clients of their intentions to participate in the PCN program.

Physicians agreeing to participate sign a contract with the state which specifies a minimum of 50 and a maximum of 1500 PCN clients. A few PCN physicians have caseloads near the 1500 limit, but most providers serve between 50 to 100 PCN clients. Physicians may also request a maximum caseload per month, and restrict enrollment to adult recipients or current patients. Family members of current patients may, however, be assigned to physicians who have declined random assignment of clients. These restrictions are identified by an 'X' status on the computer system. Interviewees estimated that between 50 and 98 percent of providers request the 'X' status, and noted that the numbers doing so are increasing.

Kansas has problems maintaining the current PCN providers due to provider dissatisfaction about a number of issues. A recent survey of PCN physicians indicated three factors which discouraged participation in the Medicaid/PCN program: (1) administrative hassles, (2) inadequate Medicaid reimbursement rates, and (3) "irresponsible" recipient behavior, specifically misuse of the emergency room, and unkept appointments. Interviewees confirmed that recipients often use the emergency room for non-urgent care. They explained that PCN providers resist providing referrals for this type of care, as physicians believe recipients should not use the emergency room as a primary care provider. However, hospital staff feel obliged to serve clients who present to the emergency room, although the hospital does not receive payment for non-urgent care provided without a referral. Recipients thus use the emergency room as an escape valve from the PCN program. The state does not have a comprehensive understanding of the reasons for this recipient behavior. Misuse of the emergency room does differ, however, by county.

Other areas of physician dissatisfaction include: recipients' lack of information and education about the appropriate use of program; the 24 hour accessibility requirement; and the referral requirement for some services, such as EPSDT or obstetrical services, and laboratory procedures. Finally, some providers are unhappy with the recipient assignment process. Local SRS office workers must call providers who have specified a restriction for their approval before assigning them new clients. However, some providers with the 'X' status are assigned new clients without the physician's approval because local SRS office workers are too busy to contact them. Recipients are sometimes asked to call the providers for approval, and still other workers

leave clients unassigned. Interviewees stressed the importance of the link between the local office and physicians.

The number of physicians willing to participate in the plan varies by county. For example, physicians in Shawnee County often refuse PCN clients, and the county currently has no PCN providers with open enrollment status. In other counties providers will accept many more clients. Interviewees did not know how many PCN providers see SSI disabled clients, or whether some physicians see a disproportionate number of the SSI disabled. Physicians have neither complained to them about the difficulty of managing particular clients, nor mentioned any issues around SSI disabled recipients.

About one and a half years ago, EDS created a new Provider Relations Representative position to improve provider recruitment and retention in the program. Interviewees noted that this is an unusual role for EDS; however, the state wanted EDS to assume this responsibility. The state's KAN Be Healthy (EPSDT) program may also hire a PCN representative. The Provider Relations Representative maintains outreach with providers via public relations and problem-solving with individual physicians. For example, the Representative has visited PCN providers' offices on a county-by-county basis to find out their concerns and answer questions. Responses to the visits have been positive. The Representative has also sent flyers to all non-PCN providers in PCN counties. They contact all physicians in PCN counties, particularly those just setting up practices. However, the PCN is having limited success in recruiting new physicians for the program. The Provider Relations Representative would like to hold workshops to encourage physician participation in the program.

VI. Quality of Care

The Primary Care Network program uses multiple approaches for monitoring and assuring quality of care. First, a hotline at the Recipient Assistance Unit at EDS is maintained to handle recipient complaints, inquiries, and problems. Second, client surveys are conducted periodically on a sample of enrollees. These surveys examine client satisfaction with access to services and quality of services covered under the waiver. The third mechanism used to monitor quality of care is the grievance system in effect under the regular Medicaid program.

Quality of care monitoring also takes place through Kansas' Surveillance and Utilization Review System (SURS), which includes a claims exception review process. Payment files are reviewed to identify over or underutilization by recipients, along with unusual physician practice patterns. For instance, providers with high expenditures and recipients with high drug use are identified through the exception review process. Interviewees noted that persons with disabilities are not often identified for review through exception indicators. Those that are identified usually have a diagnosis that explains the exception. About 20, or .05% of all providers identified through provider exception reports are targeted for review each quarter. In addition, physicians may be identified for further review through: (1) regular discussions between staff in Medicaid's SURS Unit, the Medical Board or PCN staff, and (2) reports from the Office of the Inspector General.

Other quality of care monitoring procedures include periodic claims review and medical audits to monitor physician availability, medical necessity, and appropriateness of referrals. Medicaid staff in the SURS Unit conducts in-house desk reviews of up to 20 case records submitted by the provider, more thorough on site reviews including case record reviews of up

to 100%, and face-to-face interviews with providers. They are considering adding case reviews at the local SRS office. When the Medicaid Department receives three or more complaints about a provider in a quarter, they investigate further. Quality of care problems identified through complaints and exception reporting are followed up by medical review. The Medicaid program also has a Fraud Unit. A current goal this year is to review five PCN providers with high caseloads. This review was prompted by an recent incident whereby one such provider lost his license, only to be replaced by another physician who had similar problems with the Medical Board.

Most deficiencies discovered through monitoring concern inappropriate billing problems rather than poor quality of care. For example, one current problem under review concerns a physical rehabilitation hospital which may be inappropriately billing for psychiatric services. However, there have been some complaints about specific providers which have been investigated and found to be true. Interviewees believe the number of complaints will decline with increased education about the program. Corrective action focuses first on education of the provider, if appropriate, and later suspension or termination of the physician from the PCN or Medicaid programs when necessary.

The results of the client satisfaction surveys indicate that clients are generally satisfied with the PCN program. Non-PCN Medicaid recipients have not been surveyed. There have been "no red flags" from the surveys about persons with disabilities. However, they have not examined separately the survey responses of AFDC and SSI recipients. Interviewees mentioned several areas of client dissatisfaction including the lack of choice of providers in some areas, the PCN referral system and the restriction to a primary care physician. The most recent client

survey results show possible problems with the availability of physicians after-hours, and suggest a need for increased monitoring and contract enforcement to ensure assess.

Kansas has also surveyed participating physicians and local SRS office staff to obtain information about increasing the effectiveness of the program. Results of the employee survey indicate that SRS staff feel overworked and undertrained with respect to the PCN program. SRS employee respondents also cited the need for more PCN physicians and greater enforcement of PCN regulations. Results of the Physician Survey show that providers think clients have inadequate knowledge about some aspects of the program, especially emergency room usage.

VII. Data

The PCN data system is part of Kansas' Medicaid Management System (MMIS). The MMIS system is maintained by EDS, with the exception of the recipient eligibility system. Encounters are automatically reported through the claims processing system. Kansas processes approximately 23,000 claims per day. Claims processing is identical for PCN and non-PCN clients. Kansas can obtain a claims payment history for the past 18 months.

The PCN program receives quarterly reports on each participating provider to compare their performance with practice norms. Providers are compared on emergency room visits, physician specialty referrals, inpatient hospitalizations, office visits, prescriptions, authorized laboratory procedures, and total Medicaid expenditures for services billed or authorized by the physician. PCN providers also receive monthly reports which show: (1) the full roster of PCN clients assigned to the case manager; and (2) a listing of every recipient whose monthly expenditures exceed the standard of all Medicaid recipient expenditures.

A recent program review identified some concern about the usefulness of the current management reports in providing appropriate information to effectively manage the PCN program. Medicaid staff is also in a process of clarifying its report requests. Interviewees noted that the state has a lot of data, but little usable information about the SSI disabled. At the present time, they have not compared the cost or utilization experiences of enrollees who are SSI disabled with those of other eligibility groups. This provides some explanation for the paucity of information available about the impact of the PCN program on the population of persons with disabilities.

VIII. Utilization

The Primary Care Network program uses SURS utilization review reports, post payment reviews, and special reports and computer runs to monitor service usage. Utilization review reports are shared with providers. Physicians are expected to review the monthly reports and take steps to correct overutilization, when known illnesses or conditions do not explain the problem. Physicians are not penalized for a few unrecognizable charges on the monthly reports.

Services are monitored on a post-payment basis to verify that referral was obtained. They also monitor provider and recipient eligibility, exempt procedures and provider specialties. The Kansas Peer Review Organization (PRO) conducts inpatient utilization review. Review can target hospitals and physicians. Preadmission review is also required for psychiatric, specialty, and rehabilitation hospitals.

In the PCN program, primary care providers must approve referrals for specialty care, non-urgent hospital services and other covered services. The state has established a system that

rejects claims that have not been approved by the recipient's case manager. Human error is a frequent cause of claims denials. For instance, the PCN physician's ID number is often accidentally omitted from the claim form. Providers can appeal or resubmit denied claims. Interviewees consider claims denials to be a minor concern of providers, although they involve a considerable amount of paperwork and are "a hassle".

The primary care physician is the case manager in the Primary Care Network program. MR/DD Medicaid recipients also have case managers through the HCBS waiver who coordinate enrollment in the PCN program and other services. Staff at the Special Health Services program for children control specialty referrals for their program participants.

The Primary Care Network program has arranged for program review every two years under the 1915(b) waiver extension requirements. The cost-efficiency evaluations compare the seven PCN counties to all non-PCN counties in the state on service utilization rates and costs. The state has not monitored or examined utilization rates or cost by eligibility group or by disability subgroup.

IX. Critical Issues

Kansas is a conservative, rural state with a limited HMO industry. Considerable cautiousness about managed care prevails, and capitated models appear to be less acceptable than PCCM models. Since the early eighties, physicians have displayed little interest in HMOs, and thus the HMO industry is not growing in Kansas. The few HMOs in the state are in urban areas. State employees have access to a Blue Cross/Blue Shield HMO program, but

participation is discouraged by high fees. The state has also attempted to enroll HMO providers in a managed care program, but has had little success in this endeavor.

The current status of the Primary Care Network program is unclear. Although there is pressure from the legislature and the Medicaid Department to contain escalating Medicaid costs through managed care, questions have been raised recently about the effectiveness and administration of the program. A special PCN task force consisting of representatives from local SRS offices, the Central office, Management Services, and EDS was created in 1991 to conduct an in-depth evaluation of the program. The task force identified numerous issues of concern for the PCN and recommended improvements for the continuation or expansion of the program. For example, the 1992 task force evaluation indicated dissatisfaction with the administration of the program and a lack of commitment and/or resources by the agency to address its concerns. Some of the review's recommendations include strengthening marketing and program management, and increasing education about the program for all managed care participants. Both the task force and interviewees recommended establishing an ongoing PCN advisory committee to address problems and recommend changes to the program on a continuing basis.

Interviewees also identified issues of concern with the PCN, such as: the inadequate supply of providers; the need to better educate providers, recipients, and local office staff about the program; inadequate staffing and support of the program; unassigned clients and the client assignment process; and the usefulness and accuracy of reports. Many of the issues mentioned by interviewees had been addressed by the PCN task force. These dilemmas and the state's plans to address them are described below:

1. Inadequate Supply of Providers

According to the recent 1992 evaluation, federal mandates expanding Medicaid eligibility have increased the number of Medicaid beneficiaries in Kansas since 1988, but the number of primary care physicians participating in the PCN program has not kept pace with this increase. Interviewees suggested that PCN providers are restricting the number of PCN clients they serve and eligible physicians are not accepting Medicaid clients.

The state is investigating several different approaches to resolving the shortage of PCN providers. First, other types of providers, such as Advance Registered Nurse Practitioners (ARNPs) might be used as case managers. They also want to eliminate the minimum requirement of 50 PCN clients per physician. Another option under consideration is excluding additional Medicaid recipients from the PCN, such as HCBS waiver participants. The recent program evaluation also suggested the following groups for exclusion from the PCN: recipients with HMO coverage or third party insurance, SSI adults, and MS (old Aged, Blind, and Disabled populations that receive SSA) recipients. Interviewees believe that the provider recruitment process could be improved, and reported that EDS' contractual requirements in this area were under review by the state. They are also considering television advertisements to promote provider enrollment.

2. Inadequate Staffing and Support of the PCN

Interviewees cited allocation of adequate and skilled staff as critical to the effective management of the program, noting that waiver programs--including the waiver renewal process--are time-consuming and complicated. Disability groups also complicate the management of the program. However, Medicaid officials believe Kansas has not dedicated adequate financial

resources to fund enough PCN staff at the Central or Local office level. For instance, the PCN Manager divides the month into managing seven programs. State Medicaid administrators would like at least one full-time PCN staff person, and have informed the legislature of the need for more resources. The legislature is supportive of the program, but has been reluctant to appropriate funds to increase the "head count" of state employees, particularly Central office staff. The state has instead increased the size of its contract with EDS. One independent evaluation of the PCN reported that other states, such as North Carolina and Kentucky, have significantly higher administrative budgets for managed care program personnel.

Officials also cited the lack of support from the local SRS workers as a major issue for the program. These workers dislike the administrative burden of the PCN program, and thus are not committed to the program. Interviewees believe primary care physicians and the Medical Society are supportive of the PCN, despite their concerns about the program.

3. Unassigned Clients

Because of the small provider pool in some areas and local office staff not making the assignments, a substantial number of PCN eligibles are not assigned to primary care providers. There appears to be a lack of clarity around the true extent of the problem. Interviewees estimated that between 10 and 12 percent of all PCN eligibles are unassigned. However, data reported for FY 1992 indicates that as many as 21 percent of all PCN eligibles are unassigned. Other calculations suggest the number might be even higher. The percentage of unassigned clients varies by county from 15 to 28 percent, according to FY 1992 data. Interviewees noted that in some counties, workers cannot assign new PCN clients to anyone at all. Kansas does not know the distribution of unassigned clients by eligibility category; thus it is unclear whether

access to services for beneficiaries with disabilities has been disproportionately affected by this issue.

Interviewees cited a variety of obstacles faced by local office staff in assigning PCN clients to primary care providers. The shortage of providers, the administrative burden of the program, client time to choose a provider, and outdated reports on provider practice openings all hinder the client assignment process. Interviewees identified the recipient assignment process as an area for major changes in the near future.

4. Inadequate Education about the PCN

Interviewees identified education for all managed care participants (i.e. clients, providers, local SRS office workers, and Medicaid staff) as essential for the continuation or expansion of managed care in the state. Results of recent surveys of clients, employees, and physicians, also suggest the need for more training. For example, the PCN policy stipulates that non-urgent emergency room use must be authorized by the Medicaid client's primary care provider. However, some non-urgent care is still being delivered in emergency room settings. Client Survey respondents indicated a desire to know more about the PCN, particularly how the PCN handles referrals and emergency care. Local SRS office staff lack the training and understanding to adequately address physicians' and clients questions about the PCN's policies and procedures. Kansas expects future changes in how managed care participants are educated about the PCN.

5. Usefulness and Accuracy of Reports

State Medicaid administrators identified reporting and cost analyses as weaknesses of the current system. The recent task force evaluation indicated that the design of the reports had remained unchanged since the beginning of the program, and that the reports lack the

information currently needed to effectively run the program. The state is attempting to clarify its report requests. As discussed previously, the state also questions the methodology used to conduct the required cost-benefit analysis. The 1992 program evaluation recommended several changes to the cost-effectiveness methodology, such as: using 1992 as the new base year; redesigning and using new and more accurate source documents for the analysis; and establishing a new methodology for trending and forecasting. Later in 1992, Kansas was granted a waiver of the requirement to conduct an independent cost-effectiveness evaluation. The state, however, must continue to document cost-effectiveness as part of the waiver renewal process.

Thus, Kansas is in a time of reflection about the PCN program. The Medicaid Director is expecting further staff recommendations on ways to improve the program. The state needs to overcome its current obstacles before continuing the program on a long-term basis. Medicaid officials thus expressed cautious optimism about the future of the PCN. One major concern is the impact of the current shortage of administrative resources; if unremedied, officials believe this deficiency might ultimately affect access. Moreover, although the state has no definitive data about the issue, interviewees suggested that discontinuation of the PCN might decrease access for the General Assistance and the disabled populations in particular. Providers find these groups less appealing than AFDC clients, and they would thus have an harder time getting services. The state believes it would have other avenues to control utilization without the PCN.

Interviewees believe that another barrier to the success of managed care in Kansas is the misconception that managed care will address systemic issues, such as the shortage of providers and low Medicaid fees in Kansas. The state's physician shortage is a problem for the general

population as well as for Medicaid recipients. Officials stressed that these issues cannot be resolved by managed care alone.

Kansas is currently researching other models of managed care. The state is now absorbing all the risk for high-cost clients. However, they are reluctant to push more of the risk onto providers for fear of increasing dissatisfaction. Medicaid administrators believe that the state could save money using a capitated managed care model, such as HMOs. However, the state would have to invest a significant amount of money upfront in order to benefit in the long run. Interviewees believe that the state lacks the vision to make this investment. One option that has been proposed is the consolidation of Medicaid managed care with the state employee HMO in order to leverage state monies.

X. Lessons for Other States

Kansas has had a fairly long history of developing one important model of managed health care. Other states, such as North Carolina, have used the Kansas managed care concept to develop their programs. Thus, the lessons learned from the experience of the Kansas PCN program offer a valuable model for other states interested in creating or expanding managed health care options. Discussions with interviewees suggest the following managed care components as critical to the success of a PCCM program: a well designed recipient assignment process; aggressive physician recruitment strategies; adequate training of physicians, agency staff, and clients about program policies and procedures; and funding for sufficient staff to effectively manage the program.

State officials believe that Medicaid managed care programs can be used to increase access to services for Medicaid recipients. The state hopes to improve the performance of the Primary Care Network program and implement strategies that will assure greater access to services, while continuing to contain costs. However, the state has limited evidence to support claims of increased access for the SSI disabled population. Little systematic information is available about the specific impact of the PCN program on the SSI disabled population, limiting the state's planning on their behalf. However, interviewees expressed interest in learning more about this population. Identification of the most critical data collection elements during initial or subsequent program development phases regarding persons with complex health, social and emotional needs seems to be an essential element for tracking program impacts. In the absence of such data, Kansas has had to rely on informal information channels for knowledge about these Medicaid consumers.

Information Resources:

Interviewees/ State of Kansas
Division of Medical Services, Department of Social and Rehabilitation (SRS)

Diane Davidson, Manager, MMIS Contract Monitoring

Dorothy Hunt, Manager, Communication and Special Services

Joan Lewerentz, Administrator, Program Services Section

Joyce Sugrue, Director, Division of Medical Services

Karen White, Manager, Program Integrity

Interviewees/ EDS-Federal

Toni Allston, Provider Enrollment Specialist

Kathy Johnson, Provider Relations Representative

Regina Lewis, PCN Coordinator

Jeff Strand, Systems Engineer

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Medicaid Managed Care Programs for the SSI-Disabled Population
The Case of Michigan

I. Brief Overview of the State

Michigan currently utilizes three different models of Medicaid managed health care. First, seven state-licensed, federally qualified HMOs in nine of Michigan's 83 counties receive a capitated payment from the state to provide comprehensive health services to enrolled Medicaid recipients. Michigan also contracts with four federally approved partially capitated Clinic Plans (CPs) in three counties. Finally, in addition to the two capitated programs, Michigan operates one fee-for-service (FFS) Primary Care Case Management (PCCM) program, the Physician Sponsor Plan (PSP). PSP providers are reimbursed on a fee-for-service basis, and receive three dollars per member per month to case manage recipient care plans. The PSP program engages 1849 physicians in 27 counties to serve PSP enrolleés residing in 65 counties, as reflected in data reported for February, 1993. At the time of the site visit, all three managed care programs were operating on a voluntary basis with one exception: managed care participation was mandatory for AFDC Medicaid eligibles in Wayne County.

Exclusions from participation in Michigan's three Medicaid managed care programs include residents in state institutions, Crippled Children Program participants, General Assistance recipients, enrollees of another Medicaid managed care program, Qualified Medicare Beneficiaries (QMBs), hospice care clients, spend down recipients, Qualified Working Disabled Individuals, long term care patients, and clients enrolled in the Recipient Monitoring Program.

Interviewees estimated that there were 1.2 million Medicaid beneficiaries in the state at the time of the site visit. As of December, 1992, 141,275 of the state's Medicaid beneficiaries

were eligible through the Supplemental Security Income (SSI) program. Of this group, 86% (121,126 individuals) receive no Medicare benefits.

Data from April, 1993 show that 381,488 Michigan Medicaid beneficiaries were enrolled in managed care, including 163,437 PSP enrollees, 197,567 HMO enrollees, and 20,464 Clinic Plan enrollees. SSI beneficiaries represented 40,248 or 11% of managed care enrollees. Thus, as of this date, approximately 28 percent of Michigan's SSI beneficiaries were managed care enrollees. Of the total SSI managed care participants, 23,607 were enrolled in the PSP program, 13,484 were enrolled in the HMO program, and 3,157 were in the Clinic Plan.

Michigan is moving toward a mandatory, statewide managed health care system, and is currently in the beginning phases of this transition. Officials indicated three methods for the expansion. First, the state will expand the PSP throughout the state. Officials described the PSP program as widely accepted, and fairly successful in both rural and urban areas. Thus, the PSP will be the main vehicle of the managed care expansion. In addition, they are hoping to increase the number of plans in the HMO program. Moreover, some HMOs currently under contract with the state may expand into new counties. With the exception of one CP operating in the Hospital Demonstration program, Michigan is not actively recruiting to expand the Clinic Plan program. The state has had a variety of concerns about the CPs, including its lack of data and quality oversight; these concerns will be discussed later in this report. Officials believe the Clinic Plans must be modified to resolve these issues before the program can be included in expansion plans. Finally, Michigan plans to enforce mandatory enrollment in managed care beginning on February 1, 1993, with non-Medicare SSI disabled clients in Wayne County.

Oakland, Macomb, and Genesee counties will be the next areas to undergo mandatory enrollment.

Michigan designed its Managed Care Entry Plan (MCEP) program to facilitate the enrollment of all required recipients into a managed care plan. The MCEP program automatically enrolls recipients who fail to choose a primary care physician with special MCEP providers in their geographic region. At the time of the site visit, the MCEP program had been implemented in Wayne County only. The state expects to implement this program in each new area of the state six months to one year after managed care has expanded into the new region.

Federal regulations mandate the inclusion of Federally Qualified Health Centers (FQHCs) in managed care. However, only the PSP program currently engages FQHCs as primary care providers. Michigan has 18 Federally Qualified Health Centers (FQHCs) and officials hope to increase the number of FQHCs in the state. Interviewees stated that FQHCs had not been involved in the PSP program for a long enough period to determine if cost savings would be realized, given that FQHCs receive 100% cost reimbursement. Michigan also has 12 to 15 Rural Health Clinics (RHCs). Currently, RHCs and many FQHCs do not meet the 20 hour physician on-site requirement that would permit them to participate in the state's managed care programs. However, officials are attempting to change the criteria so that other types of providers, such as physician assistants and nurse practitioners can assist in fulfilling this requirement. With this regulation change, RHCs can be included in managed care. Michigan expects to have 50 Rural Health Clinics in the state by the end of 1993, and hopes that many RHCs and more FQHCs will participate as managed care providers once the regulation change is approved.

The Medical Services Administration (MSA) of the Michigan Department of Social Services (MDSS) oversees the state's Medicaid program. The MSA is organized around a central office located in Lansing, the state capitol. The MSA employs over 400 people, and consists of five units: Support Services, Fiscal Review, Program Policy, Health Services Review, and Medicaid Operations. The Bureau of Medicaid Operations contains the Claims Processing Division and the Special Processing Division; its responsibilities include claims processing, provider enrollment, and managed care. Within the Special Processing Division are three sections: the HMO Section, which also oversees the CP program; the PSP Section; and the Document Control Section. Approximately forty people work in this Division. At the time of the site visit, Michigan had just begun the process of integrating the managed care sections into the rest of the MSA. The reasons given for this integration are discussed later in the paper.

Michigan operates several special programs for persons who are ventilator dependent or have a traumatic brain injury. These two programs together serve approximately 130 clients. In addition, Michigan has a number of demonstration projects that serve individuals with complex health, social and emotional needs. The Michigan legislature recently allocated $10 million for these Medicaid Health Care Delivery Demonstration Grant Projects. In 1992, the Michigan Department of Social Services awarded grant funding to 16 projects. Several of the projects chosen are studying managed health care delivery systems. Many of the demonstrations serve special populations, including chronically ill children, and persons with mental illness, physical disabilities, AIDS, or a dual diagnosis (mental health/substance abuse). At least four projects focus on mental health issues.

II. History of Managed Care Development in Michigan

Michigan's investment in Medicaid managed care development began in 1971. Officials cited two key factors which led to the initiation of managed care in the state. First, Michigan's Medicaid Director became interested in including HMOs in the Medicaid program as a way to get involved "in the capitation arena". Commercial HMOs had been operating in the state for a number of years prior to 1971. Second, access to prenatal care had become a problem in some areas of the state. Subsequently, the Model Neighborhood Program was created through collaborative efforts between the Department of Public Health and the MDSS to assure access to care for poor, pregnant women. Thus, the state was seeking ways to increase access, and prenatal care was the first impetus for change. The state's HMO program grew out of the Model Neighborhood Program. The state currently contracts with much more mainstream HMOs.

The MSA established its first Medicaid pre-paid contracts in 1972. These early contracts were solely with HMOs. Thus, Michigan was one of the first states to establish a Medicaid HMO program. The state's managed care initiative began in the Detroit-Wayne County area, as approximately one-third of Michigan's Medicaid recipients reside in this region of the state. At the time of the site visit, Michigan had contracted with HMOs in Wayne County for twenty years. The HMO program began as a voluntary program. However, later, as Medicaid managed care developed in the state, AFDC recipients in Wayne County were required to choose among the managed care options.

In the early 1980s, Michigan began to examine and develop additional managed care options. First, the Physician Sponsor Plan program was developed by the MDSS and two

Michigan medical organizations--the Michigan State Medical Society and the Michigan Association of Osteopathic Physicians and Surgeons. Physicians at the two medical societies initiated the PSP program in response to a legislative request for proposals on alternative reimbursement strategies. The Legislature provided the MDSS with the authority to create the program.

The PSP program was established in 1982 by the Michigan Department of Social Services under a 1915(b)(1) Medicaid waiver. The waiver allowed the PSP program to operate as a mandatory managed care program for the AFDC population in certain geographic areas of the state. SSI beneficiaries were not required to participate, although they were allowed to enroll on a voluntary basis. The PSP program was first implemented in Wayne County in 1982, and expanded in 1986 to Genesee County in mid-Michigan, and to rural Marquette County. As of February 1993, the program served residents of 65 counties.

Interviewees believe that, until recently, Medicaid managed health care in Michigan received little support from state government outside of the MDSS. However, in 1991, Michigan's new Governor adopted the PSP as part of his strategy to strengthen Michigan families. Although the Governor began to "right-size" government, and many MSA staff lost their jobs that year, the PSP program was presented as an effective project which increased quality and access while cutting costs. Thus, with the Governor's blessing, the PSP gained high priority status.

The Clinic Plan program was developed by two provider groups in different parts of Michigan. The providers created a plan based on the HMO model. However, unlike HMOs, Clinic Plans are partially capitated and at risk for outpatient services only. The state received

a federal waiver and implemented the CP program on a pilot basis in 1983. At the time of the site visit, Michigan had four Clinic Plans: three in Wayne county and one in Muskegon County. These plans are private for-profit organizations. Although inpatient hospital charges are the responsibility of the state, each CP must authorize inpatient services.

CPs are currently neither state licensed nor federally qualified plans. However, as described earlier, the Clinic Plans may soon go through a structural change. Interviewees indicated that, to allow for expansion, Michigan would like to convert the CPs into Alternative Health Care Financing and Delivery Systems (AFDS) to be licensed through the Michigan Department of Public Health. Under this special licensing program, Clinic Plans would have to meet requirements similar to state-licensed HMOs. However, since the time of the site visit, officials have reported that Clinic Plans will now be required to obtain Medicaid Clinic Plan licensure in lieu of AFDS licensure. Michigan is now in the process of developing and implementing the standards and protocol for Medicaid Clinic Plan licensure.

Although the SSI disabled population has been allowed to enroll in the HMO, Clinic Plan, and PSP programs, Michigan has minimal information about the experience of SSI recipients in its Medicaid managed care system. One interviewee described the SSI disabled population as "a black box". The state has the most knowledge about the participation of SSI beneficiaries in the PSP program. For instance, they have some information about cost-effectiveness and quality of care for the SSI disabled population through evaluations of the PSP program.

In addition, Michigan has heard from advocacy groups about the participation of SSI beneficiaries in the PSP program through the PSP Advisory Committee created in 1981. This

group was composed of representatives from the Michigan Legislature, the Michigan State Medical Society, the Michigan Association of Osteopathic Physicians and Surgeons, and advocates from both the legal and service sectors. The committee was formed to address potential problems in the PSP program before they occurred. A subcommittee monitored SSI issues. Interviewees believe that the subcommittee slowed the implementation of the Physician Sponsor Plan, but also strengthened the program. As a result, the state has not had much opposition from advocacy groups.

The PSP Advisory Committee was dissolved one year ago, and the Managed Health Care Advisory Committee was created to advise on Medicaid managed care in Michigan. This group's composition is similar to that of the committee created in 1981; however, the new committee advises on all three managed care programs. The committee receives updates on managed care developments through regular presentations by the MSA.

In general, officials believe that the outlook of advocacy groups is changing in favor of Medicaid managed care. Advocacy groups have been less vocal in response to the mandatory enrollment of the SSI population than they were to earlier issues around managed care for this population. However, the state has recently received an information request from Legal Services, and suspects a challenge to managed care. They do not know where the request originated. Because managed care has the endorsement of the Governor, officials believe the Executive Branch will back them up if any problems arise with advocates or Legal Services.

Officials doubted that providers would be greatly affected by the mandatory enrollment of SSI recipients in managed care. However, they believe the change may be confusing for SSI recipients. The state is attempting to deal with this possibility via presentations and outreach

activities. Presentations on managed care have been made at Community Mental Health Centers (CMHCs), the Headstart program, MDSS offices, and senior citizen centers. The state expects to hear from many SSI recipients in the near future with problems or questions about managed care. They will be able to disseminate information on managed care to the SSI population through the process of handling these inquiries and complaints. One interviewee stressed, however, that many SSI recipients currently enrolled in managed care have had few problems with the system.

Complaints from SSI recipients about the mandatory enrollment will also facilitate the identification of subpopulations needing special attention around managed health care issues. With the exception of the AIDS population, the state has found it difficult to determine who these groups might be. Interviewees noted that it will be a while until the impact of mandatory SSI enrollment is understood. They don't know what they "have charged into" with the mandatory managed care expansion. However, Michigan believes it has an out via its enrollment exception policy. This exception policy is a source of comfort to the advocacy groups. Despite the policy, Medicaid officials believe that the SSI population is a group that can benefit from managed care.

III. Financing and Reimbursement

Michigan's HMOs are required to provide 24 hour access to the full range of Medicaid covered services, including ambulance, family planning, hearing aids, home health, hospital, laboratory, medical supplies, methadone maintenance, pharmacy, physician, podiatry, and vision services. Services not covered by HMOs include hospice, long-term care, community mental

health services, and dental services. Medicaid recipients needing hospice or long-term care services must disenroll from the HMO and receive services under the FFS system. Recipients may receive dental services or community mental health services through the FFS system and remain HMO members. HMOs are at full risk for all covered services.

Michigan's Clinic Plans receive a partial capitation payment and must render or authorize all Medicaid covered services except dental, hospice, long-term care, and community mental health services. The Clinic Plans are not at risk for inpatient facility charges, but must authorize all inpatient services. Like HMO enrollees, Clinic Plan enrollees requiring long-term care or hospice services must disenroll from the CP program and receive services under the FFS system. Recipients may receive dental, community mental health, and inpatient hospital services and remain enrolled in the Clinic Plan. Providers earn a savings bonus if inpatient utilization is reduced to 80 percent of the expected FFS cost. The state and the providers share the savings. Providers are not penalized if inpatient costs are higher than what would have been expected under the FFS system.

Before 1980, HMOs were reimbursed on a cost basis. In 1980, the state switched to a rate setting methodology. The methodology has remained unchanged since that time. HMOs and Clinic Plans are currently paid a monthly capitation rate per enrollee. However, unlike HMO rates, capitation rates for Clinic Plans do not include reimbursement for inpatient hospital services. The MDSS bases the capitation rates on the FFS costs of a like population for covered services. Michigan has 24 capitation rate categories based on county, age, sex, program, and category of assistance. Staff in the MSA's Institutional Policy Division is responsible for rate setting for the two capitated managed care programs. Rates are first calculated, and then

offered to the HMO or Clinic Plan. There is no negotiation between the state and the plan about rates.

In general, the HMOs believe the capitation rates are too low. Officials reported at the time of the site visit that the HMOs had not complained specifically about the rates for the SSI disabled population. Interviewees suggested that HMOs pay little attention to these rates because these types of plans have few SSI enrollees. HMOs have complained about rates for other Medicaid eligible groups, however.

The Consultant currently employed by the state's HMO Association is a former MSA employee. Officials believe they are fortunate to work with an individual who understands the MSA. The state has had eight successful meetings about rate-setting with the HMOs since August, 1992. The most recent meeting focussed on capitation rates for mental health services, and the EPSDT reporting system for HMOs.

The MSA currently contracts out for actuarial services. They are also planning to contract out for rate setting services, due to recent concerns about the process of rate-setting. Interviewees explained that the Office of the Inspector General (OIG) recently cited the MSA in a rate-setting audit. They have no concerns with the rate-setting methodology.

Michigan does not provide stop-loss reinsurance to its capitated managed care programs. The state investigated this option in 1986; however, HMOs were not interested in purchasing reinsurance from the state at that time. Interviewees reported that HMOs are currently interested in the subject, and would like the MSA to offer this type of coverage. They stressed, however, that the HMOs are not pushing the state on this issue. The MSA Department needs encounter level data from the HMOs in order to create stop-loss coverage, but does not obtain this type

of information from the plans. Officials believe the state will have a difficult time providing stop-loss reinsurance unless this issue is resolved.

The Physician Sponsor Plan is a non-capitated primary care case management program. PSP physicians are reimbursed for the medical services they provide on a fee-for-service basis. In addition, providers receive a monthly $3.00 patient management fee per enrollee for their coordination role on behalf of the Medicaid clients assigned to their care. Providers may serve a maximum of 2000 PSP enrollees; however, they receive case management fees for the first 1000 clients only. Interviewees reported that the fees have more of an impact in urban areas, where case management fee payments can be substantial for physicians with high caseloads. Conversely, the case management fee is less of an incentive for physicians in rural counties: these areas have fewer PSP enrollees, and thus physicians earn less money from the patient management fees. The PSP dropped co-payments a few years ago to encourage enrollment in the program. The state views this change as sharing savings with recipients.

Managed Care Entry Plan (MCEP) providers receive reduced reimbursements in exchange for a significant volume of automatically enrolled clients. For example, MCEP providers in the PSP program do not receive per enrollee case management fees for the MCEP clients they serve. The capitation rates for MCEP clients in the HMO and CP programs are five percent less than the rates for other HMO and CP enrollees.

Michigan does not have special financing arrangements for persons with specific disabilities. However, officials mentioned that the state currently has a demonstration project that uses increased case management fees for enrolled disabled children in Wayne County.

Moreover, they have added dollars to the rate base to try to trend forward for the incidence of AIDS.

The PSP and Clinic Plan programs are evaluated as part of the waiver renewal requirements. Michigan estimates that the Clinic Plan program has resulted in a 12% savings to the Medicaid program. Total estimated cost savings for the HMO program up to 1990 is $96 million, based on the differences in expenditures for HMO enrollees compared to expenditures for FFS recipients. Michigan has not compared the cost and utilization experiences of HMO or Clinic Plan enrollees who are SSI disabled with those of other eligibility groups. Thus, there is a paucity of information about the impact of the HMO program and the Clinic Plan program on the population of persons with disabilities. The 1992 evaluation of the PSP program compared the cost-effectiveness of AFDC and SSI recipients enrolled in the program to that of their FFS counterparts. Results of this study confirm the cost-effectiveness of the PSP for these two groups compared to FFS enrollees.

IV. Marketing and Enrollment

Enrollment in Michigan's Medicaid managed care programs has been voluntary for all Medicaid eligibles except AFDC recipients residing in Wayne County. However, as described earlier, the state is currently in the process of a mandatory, statewide expansion of Medicaid managed health care. Clients have a choice of all three managed care programs if available in their area.

Enrollment in a Medicaid managed care program may occur in one of several ways. First, recipients are mailed a list of available providers in their area, along with a "Choose

Now" booklet which describes the different managed care options. Recipients may then return the enrollment form included in the booklet to the MSA. Second, all managed care providers, including HMOs, CPs, and PSP physicians, have enrollment forms available in their offices. Third, recipients may enroll through an 800 number at the MSA. Messages may be left after hours. Individuals also receive a Choose Now booklet when they apply for Medicaid at their county MDSS office, and may enroll at this time. Interviewees believe the most effective vehicle of enrollment is providing recipients with a choice of managed care programs. Enrollment of the SSI population in managed care does not differ from enrollment of other eligibility groups. Officials believe that SSI beneficiaries tend to remain with their current physicians, and thus are the quickest population to enroll.

Interviewees reported that the state does not provide guaranteed eligibility for Medicaid recipients enrolled in the HMO program. Clients who lose Medicaid eligibility also lose their HMO coverage at the end of the month. However, clients who lose eligibility are kept on the data system for three months, and are automatically reinstated if they regain eligibility within this time period.

PSP marketing is conducted primarily through mailings and information provided at sponsors' offices. Medicaid recipients may also ask their non-PSP physician to join the PSP program. Officials reported that PSP enrollees usually stay in the program with the same doctor. Marketing to potential enrollees is the primary responsibility of the HMOs and Clinic Plans. However, the MDSS has also been involved in a number of pilot marketing efforts with the HMOs in the past. HMOs market to Medicaid recipients primarily through direct mailings and door-to-door marketing in areas known to have a high concentration of Medicaid recipients.

Door-to-door marketing has been the most successful HMO marketing strategy; HMOs have found mailings a somewhat less effective marketing strategy, with response rates of about four percent. Marketing at providers' offices has also proved successful. There has been little evidence of illicit marketing practices by HMOs in the state. HMOs maintain close communication with one other in order to quickly curb these types of problems.

Clinic Plans also use the door-to-door marketing technique. Other CPs market by telephone. However, the CPs' enrollment figures are much lower than the state had expected. Officials believe more staff is needed to monitor and enroll clients in the Clinic Plan program.

The MCEP program is a recent change in the managed care enrollment process. The program is the main vehicle for enforcing mandatory enrollment in managed care. Interviewees reported that although managed care was officially mandatory for AFDC recipients in Wayne County before 1992, the state was not able to implement this requirement, since clients were assigned to providers by hand. This process made it difficult to track client assignments, and thus many recipients remained unassigned. The state implemented the MCEP program in October, 1992 for AFDC recipients in Wayne County, and now uses computers to handle the assignment process. Although these changes have greatly facilitated the mandatory enrollment process, officials noted that approximately 7000 AFDC clients per month remain unassigned in Wayne County at this stage.

The MCEP program requires all recipients to choose a provider or request an exception, or otherwise be enrolled with an MCEP Provider. All non-assigned recipients are notified of this requirement and sent a mailing which requests a choice of provider. Recipients who fail to choose a physician from one of the three managed care programs are assigned to the MCEP

District provider. Assignment takes about 90 days, and recipients may continue to see other physicians during this period. Thus, clients have three months to select a provider of their choice before the MCEP provider enrollment becomes active. Approximately fifty percent of recipients do not choose a provider. MCEP recipients may choose another provider even after they have been assigned. The new physician selected may be a non-MCEP provider. Interviewees stressed that it is the recipient's responsibility to initiate this move.

Approximately five to ten percent of HMO and CP enrollees are SSI disabled recipients. This population has never been barred from enrolling in these two programs, and neither program is allowed to limit the number of SSI enrollees. Interviewees believe there has been no selection bias or negative marketing techniques by the HMOs with respect to the SSI disabled population. They noted that SSI recipients usually have their own providers, and are thus less likely to change to a new and different system of care. Officials cited the HMO marketing experiences, anecdotal information, historical data from states, information from advocacy groups, claims data, and the exception experience of SSI disabled recipients as corroboration for a pre-existing system of care for this group.

Michigan does not expect any biased selection with the mandatory enrollment of the SSI population. However, interviewees suggested that biased selection could occur through geographic selection by providers. The MSA could retaliate in a variety of ways if it discovered HMOs targeting to certain populations.

Some enrollment issues have arisen around clients with AIDS. Providers have requested that they be allowed to disenroll HIV positive clients. The MSA does not allow this practice as a result of the Americans with Disabilities Act (ADA). Moreover, the mandatory enrollment

of SSI recipients is focusing attention on this particular issue, and has forced the MSA to become more responsive to the needs of this subpopulation. The enrollment change may also force some adjustments in the provider community.

Exceptions to mandatory enrollment are decided by the Exceptions Officer at the MSA. At the time of the site visit, interviewees indicated that the MSA had no formal exception policy; the Exceptions Officer makes the exceptions on an case-by-case basis. Exceptions are given primarily to individuals with life-threatening diseases or mobility-limiting disabilities. Examples of exceptions granted include recipients with cancer or heart conditions, persons with conditions necessitating the use of a wheelchair, persons who are blind, car accident or stroke victims, and those persons with multiple health problems and no participating sponsor. Clients with mental illness, lupus, AIDS, asthma or MR/DD also request exceptions. Borderline cases are usually granted an exception to managed care. Exceptions are also granted to those clients without participating physicians, who request an exception. Clients may appeal a denied exception request through their county caseworker or through the MSA appeals process. Interviewees indicated a desire to know more about exception criteria used by other states.

Recipients may request an exception by calling the 800 number at the MSA. The Choose Now booklet mailed to recipients lists this telephone number. There is no exception form to fill out; the MSA does not want the process to be too easy. Providers may not request exceptions for their patients. Rather, the onus is on the recipient or the recipient's legal guardian to call and make the request. The actual exception review time ranges from one to thirty minutes. The Exceptions Officer looks out for requests from persons with certain disabilities and recipients with providers already on the sponsor list. A temporary exception is often granted before the

final decision is made. At the time of the site visit, interviewees indicated that exceptions were granted relatively freely, and that the process had been almost trouble-free for the MSA.

Approximately one to two percent of the AFDC population qualify for an exception. They will not know how many SSI recipients will be eligible for an exception until two to three months after the mandatory enrollment of SSI recipients is completed in certain counties. About four months ago, the state mailed approximately 8,000 letters to SSI recipients in three expansion counties: Macomb, Oakland, and Genesee. These expansion counties are still operating their managed care programs on a voluntary basis. About one half of these recipients ignored the letter; they neither chose a provider nor requested an exception. Roughly 800 SSI recipients from these counties have requested exceptions, and about 600 exceptions have been granted. Thus, over eighty percent of SSI recipients who responded to the mailings are assigned to a managed care provider, but the majority of recipients requesting an exception are granted the exemption.

Interviewees believe that the exception process may become more difficult with the move to mandatory enrollment in the expansion counties. They will have to wait until the MCEP program expands into the three new counties to deal with recipients who ignored the letters. Approximately 30,000 letters about the mandatory enrollment were sent to SSI recipients in Wayne County in mid-January. These recipients were asked to choose a provider by March, 1993. They expected to hear from 15,000 of these recipients and enroll the remaining recipients in the MCEP program. Several thousand SSI disabled in Wayne County were already voluntarily enrolled in managed care at the time of the site visit. They do not expect many exception requests in Wayne County because of the many sponsor options available to SSI

recipients in that area. They also doubt that many recipients will use the MCEP program on a permanent basis.

V. Provider Participation

The Physician Sponsor Plan contracts with 1849 physicians in 27 counties. At the time of the site visit, almost half of all PSP providers were located in Wayne County. Providers agreeing to participate in the program sign a contract with the state which specifies a maximum of 2000 PSP clients. Providers receive case management fees for the first 1000 clients only. There is a wide range in the size of PSP physician practices. PSP providers may set their own enrollment limits. Some providers do not want new clients, but will sponsor their current patients. Physicians can easily refuse new PSP patients if their caseload is full, and find it hard to refuse to sponsor current patients. They can easily open and close their managed care caseload by calling the MSA. However, providers with open caseloads are not supposed to refuse clients unless they can demonstrate an inability to provide appropriate care.

One interviewee mentioned that it might be possible for providers to refuse to serve SSI disabled clients. This could happen as the managed care becomes mandatory. In general, however, the state believes that providers will not decline to serve clients based on recipients' Medicaid eligibility categories. They contend that most physicians who serve Medicaid clients have a strong social conscience.

In October, 1992, the PSP program began expanding into new areas of the state. The program is currently operating on a voluntary basis in these counties. The MSA employs a Marketing Analyst to encourage providers in these counties to join the PSP. Current efforts in

this area include marketing to providers, and outreach and training activities. The new areas are much more rural than Wayne County. Interviewees noted that providers in rural areas are less willing to be involved with the PSP program than physicians in urban counties. However, officials believe rural providers are already "doing managed care", and just need to be convinced of this fact. Thus far, the overall response from physicians has been positive. At this stage, the state has only marketed the program to Medicaid providers; later, non-Medicaid providers will also be targeted. Michigan would also like local health departments to become qualified as managed care providers in order to increase managed care penetration in rural counties.

Interviewees reported providers' major concerns with the PSP. The biggest issue for physicians is the 24 hour access requirement. In particular, providers in rural areas have difficulty in meeting this requirement. Physicians' second major concern is the PSP physician approval requirement for emergency room services. Many physicians have liability concerns about the approval requirement. Also, physicians believe they must then evaluate and treat the client if they do not authorize emergency room services. PSP providers also want a referral network in order to have the resources necessary for the care of their patients. More specifically, they would like to know which specialists will accept Medicaid clients. Unlike PSP providers, HMOs already have referral networks. Providers also have general concerns about Medicaid, such as the inadequate reimbursement fees. In this case, interviewees stressed, physicians are objecting to Medicaid, not managed care.

Medicaid officials believe that physicians support the managed care concept. In particular, physicians like its focus on decreasing Medicaid abuse and duplication of services. They also want their tax dollars spent more efficiently. Interviewees believe the concept of

managed care is more important to PSP physicians than the case management fees. As described previously, seven HMOs and four Clinic Plans also provide managed health care services to Medicaid recipients in Michigan. Seventeen HMOs currently operate in the state, seven of which contract with Medicaid. All seven HMOs are required to accept SSI disabled enrollees. Interviewees indicated that the MSA is actively recruiting the other ten HMOs in the state to join the program. However, capitation rates are an area of concern for these plans. The state would like to raise these rates, but is constrained by budgetary factors. HMOs currently under contract with Medicaid are concentrated in Southeast Michigan; rates for these plans are higher than those for plans in other parts of the state. Thus, in the past HMOs in other areas of Michigan have been less interested in working with the MSA.

However, the HMOs' outlook has changed somewhat recently because of the mandatory enrollment. Officials described the HMOs as enthusiastic about the expansion, and reported that the ten HMOs not under contract with the state were now interested in joining the program. Interviewees cited several reasons for the new interest. First, the state's HMO association is encouraging HMO participation with the Medicaid program. Moreover, HMOs are looking to increase revenues in new ways because the weakened economy has increased losses in the private sector. Finally, HCFA recently held a federal meeting in Region 5 for HMO representatives to encourage HMO involvement in Medicaid managed care. Michigan is not recruiting additional providers to serve under the Clinic Plan program. They are not seeking to expand the program until they're sure that the licensing arrangement resolves their concerns.

At the time of the site visit, the MCEP program had been implemented in Wayne County only. Michigan originally contracted with 13 MCEP providers in Wayne County; subsequently,

however, the state lost two contracts. Thus, eleven MCEP providers currently operate in Wayne County. Each district has an MCEP District Provider who is assigned recipients who fail to choose a managed care provider. The MCEP program includes all three types of managed care providers: HMOs, Clinic Plans, and PSP physicians. All eligible providers were allowed to bid for MCEP contracts. Approximately fifty percent of recipients in Wayne County participate in the MCEP program, and about half of all MCEP clients eventually choose a non-MCEP provider. Thus, only 25 percent of recipients remain with providers whom they did not choose. MCEP providers are not allowed to set their own enrollment limits. Oakland, Macomb, and Genesee Counties will be the next areas to receive MCEP providers. The state is planning to wait one year for the provider base to increase before implementing the MCEP program in these counties.

VI. Quality of Care

The quality of the care delivered in each of Michigan's Medicaid managed care plans is monitored and controlled in several different ways. First, the Department will only contract with HMOs that are appropriately licensed and certified. In addition, the MSA conducts on-site inspections of HMOs for contract compliance every other year. These inspections include reviews of the claims processing system, insurance policies, random samples of grievances filed, and other relevant information. HMOs must also submit certain items for review, including current Medicaid marketing materials, and updated listings of subcontractors. The HMO receives a report of the findings after the on-site inspections have been completed.

The HMO program is also monitored by two other state agencies: the Insurance Bureau of the Department of Licensing and Regulation, and the Department of Public Health (MDPH). The Department of Public Health has primary responsibility for quality oversight of HMOs. The MDPH monitors the HMO health care delivery system, including medical records requirements, provider staffing levels, physical plant, quality assurance programs, enrollment activity, utilization reporting, required services, and subcontracts for all referral services. The MDPH also conducts annual on-site inspections of medical records. The MDPH provides the MSA with copies of medical record reviews, quality assurance program reviews, deficiency reports, corrective action requirements, and follow-up reviews. The Insurance Bureau of the Department of Licensing and Regulation monitors the financial conditions of the HMOs, and HMO grievance programs and procedures. HMOs must include a report of grievance statistics as part of their annual financial report. Client satisfaction surveys are conducted by HMOs as part of their licensure requirements. Finally, federally qualified HMOs have a six month lock-in period. Other managed care plans have no lock-in; thus, clients may disenroll at any time.

Quality in the Clinic Plan program is monitored as part of the waiver renewal requirements. The MSA conducts annual on-site inspections for contract compliance. In addition, a federally qualified contractor is required to conduct annual quality assurance reviews for the Clinic Plan Program. No problems were found with the CPs. However, at time of the site visit, the contract had lapsed, and was just about to be reinstated. State officials indicated that quality assurance monitoring had not been sufficient recently. Interviewees stressed that quality has not been well monitored in the Clinic Plan program, and a thorough quality review of the program has not been conducted. For instance, although the Clinic Plan is required to

have an ongoing internal quality assurance program, the state has no method of assuring that CPs are fulfilling their obligations in this area. Interviewees also mentioned recent charges of fraud for some CP providers involved in the managed care program. They explained that the state has had some difficulties with non-licensed personnel providing services at the CPs. Consequently, the Clinic Plan was described as the "downside" of the capitated system due to the lack of oversight and data. These deficiencies in quality assurance are the impetus for the additional licensing requirement proposal.

Quality of care is monitored in the PSP program as part of its waiver renewal requirements. Both providers and recipients in the PSP program may phone in complaints, and all problems are investigated. Corrective action for providers may result in contract sanctions or termination. Quality of care monitoring also takes place through on-site reviews conducted to assess PSP contract compliance. On-site reviews are also used to educate providers about managed care. MDSS contracts with an independent agency for access to care and quality of care assessments. The contractor monitors provider availability and conducts client satisfaction surveys six weeks after enrollment and then again six months later. The results of the survey indicate that PSP enrollees are generally satisfied with the program. The PSP is also subject to the traditional Medicaid utilization review process. Finally, studies have been conducted which compare quality of care for Medicaid beneficiaries in the PSP program with care provided to those in the fee-for-service (FFS) system. Results of the FY 89-90 study indicated that quality of care for PSP clients was modestly superior to care provided to FFS clients.

Michigan has a special quality assurance program for the smaller programs serving ventilator dependent individuals or persons with traumatic brain injury. Medicaid staff visit these providers every four months to review care plan and staffing requirements.

The state would like to improve quality of care assessment for persons with disabilities, and assure that this group is receiving good medical care. They would like to be able to talk positively about managed care's increase in access, quality, and care coordination for this population.

VII. Utilization of Services

Michigan's capitated health plans are responsible for managing the utilization of their enrolled Medicaid recipients. The primary care physician is usually the case manager in the HMO and the Clinic Plan programs. Clinic Plans must authorize use of inpatient services, although they are at risk for outpatient services only. Medicaid will not pay for non-authorized services. Both HMOs and Clinic Plans internally audit their inpatient hospital costs and utilization. Moreover, both HMOs and Clinic Plans by-pass the Michigan Peer Review Organization (MPRO) prior authorization review and HMOs bypass the postpayment review plan. Provider patterns can not be examined under the Clinic Plan program due to a lack of oversight capability, and this is a cause for worry among Medicaid officials.

The primary care provider is the case manager in the PSP program, and must approve referrals for specialty care, non-urgent hospital services and other covered services. The following services do not require the primary care provider's authorization: life threatening emergency services, hearing and vision screening, chiropractic care, podiatry services, and some

psychiatric outpatient and inpatient services. Physician authorization is also not required for federally funded family planning clinic services and maternal and infant support services: the state does not want to impede access to this type of care. PSP physician approval is not directly required for pharmacy, lab, and x-ray services; however, these services must be ordered by a physician who has been authorized by the PSP provider. Medicaid officials believe that providers know which services are examined under the state's utilization review system.

PSP utilization review is identical to utilization review under the fee-for-service system, but includes monitoring to verify that a referral was obtained. The state has established a system that rejects claims that have not been approved by a recipient's case manager. Rejected claims are sent back to primary care case managers for approval. Interviewees noted that this does not occur often; thus, the system appears to be working. They also monitor recipient eligibility and inpatient hospital authorization. The Michigan PRO serves as the actuary for all fee-for-service clients, and must approve inpatient hospitalization for PSP clients as well.

The Recipient Monitoring Program is similar to the PSP, but is directed at Medicaid abusers, particularly overutilizers of medications and emergency room services. Clients in this program are restricted to one provider. They are first allowed to choose a Recipient Monitoring physician, and are subsequently assigned a provider if they fail to make a choice. The Recipient Monitoring program has a stricter review process for certain abusers.

The Bureau of Health Services Review has a special utilization review program for the SSI disabled population. The program goes into effect when the data system identifies overutilization by an SSI disabled recipient for a few quarters. This extra review step was started after the Surveillance and Utilization Review System (S/URS) went into effect, and many

SSI disabled clients were identified for review. At the time, Legal Aid advocated for this group, asserting that these clients legitimately require additional services. Under this program, in-house physicians review a summary of paid claims by client, noting diagnosis, prescriptions, and physician referrals. The physician examines the usage pattern of each SSI disabled client. Although this activity is labor-intensive, they have had fewer client complaints or aberrant claims as a result of the program. Thus, there have been fewer concerns around utilization by SSI disabled clients. The Department has not examined utilization by disability subgroup.

VIII. Data

Michigan's Medicaid program does not receive person specific data for clients enrolled in the HMO or Clinic Plan programs. HMOs do provide the state with aggregate utilization and enrollment reports on a quarterly and annual basis. HMOs must also include a report of grievance statistics in the annual financial report. The state receives monthly invoices from HMOs and Clinic Plans. They are currently working with capitated plans to arrange for delivery of person specific EPSDT data. Medicaid officials would like to obtain other types of person-specific utilization data from these plans. However, previous attempts to procure encounter data from these plans have not been successful, and thus the state is not currently pursuing the issue.

The state receives little information from the Clinic Plans. They also described the CP's bonus settlement process as complicated and problematic, and thus labor-intensive. They believe the Clinic Plan program does not have enough systems support.

The state has good data from the PSP program, with encounters automatically reported through their claims processing system. Claims processing is identical for PSP providers and

fee-for-service providers. PSP providers receive periodic utilization reports to assist in patient care management.

IX. Current and Future Issues

Michigan would like to eventually enroll all Medicaid recipients in a mandatory, statewide managed care system. Originally, the state had planned to achieve this goal by the end of 1994. However, the time frame for the expansion has been modified. Officials explained that they had not fully understood the complexities of expanding a managed care system. For example, physician networks must be created, and this step requires time. Currently, the managed care staff is evaluating its efforts, and modifying procedures. The state is attempting to address concerns about the expansion before they become problems. They are now taking a more unique approach to each county with respect to the expansion. Michigan's current goal is to gain a managed care presence in all 83 counties in the state by the end of 1994. The chief objective of the expansion is to increase access to care as much as possible.

Officials hope to contract with all seventeen HMOs in the state. However, there are currently no HMOs in some rural counties; thus, this managed care model may never be appropriate for these areas. Officials believe the PSP program will be the most far-reaching managed care program in the state, and the only realistic plan for certain areas. However, the PSP program may have to operate on a voluntary basis in rural areas with an inadequate supply of physicians. Moreover, the managed care concept is less accepted in rural areas. Thus, Michigan recognizes that a full expansion of managed care into all areas of the state may not be possible.

At the time of the site visit, Michigan had just begun the process of integrating its managed care division into the rest of the MSA. Officials reported several reasons for the current need for integration. First, interviewees described the current managed care staff as spirited and goal-oriented, operating with a great deal of flexibility. They explained that the dedication of the managed care staff, along with access to top administrators in the state has contributed to the success of the program. However, the flexibility and accentuated significance also created some discomfort among staff in other areas of the Medicaid program, creating the potential for a schism between various sections. Second, the state has a $50 million deficit, and has instituted a hiring freeze in all areas of the MSA. However, the managed care division was exempted from the hiring freeze, and was given permission to hire eight new staff members. Interviewees reported that this hiring advantage further strained relations within the MSA, as other areas needed staff as well. Thus, the managed care division had not yet hired any new staff members because of the sensitivity of the issue. Officials hope the integration will help resolve these issues. Moreover, managed care staff support the merger with the rest of the Department because more people will be "brought into the fold" of managed care. However, they hope the managed care programs will continue to receive the same amount of support under the new Department organization. The managed care expansion has forced the state to examine some critical issues, such as high utilizers. This group includes the SSI population. Officials believe the potential for managed care is greatest for SSI disabled recipients in terms of cost savings and increasing quality of care. The mandatory enrollment of the SSI population will also prompt an examination of the feasibility of including special populations in managed care. Michigan identified eight to ten special populations last year to consider for inclusion in managed

care. After the expansion, officials will identify which groups need special attention around managed care, even if minor. The state will try to integrate these groups into managed care programs as much as possible. At this stage, they do not know whether they need new managed care systems for special populations.

The state has some concerns around managed care for persons with serious mental illness. The state has met separately with HMOs and local Community Mental Health Boards around this issue. Both of these groups believe they are responsible for managing the mental health care of enrollees, and this has created a contentious situation. For example, HMO enrollees may be admitted to the hospital by the CMHC without the HMO's authorization. As a result, the HMO will not pay for the hospital services, and the hospital is forced to "eat the costs". Representatives of the HMOs and the Community Mental Health Boards are now beginning to meet to try to address the problem. The state has asked the Boards to develop proposals for developing a psychiatric managed care system. They are considering granting complete case management responsibility for persons with serious mental illness to the Boards. Michigan has reviewed other states to assess the feasibility of capitating mental health services, but has not decided whether they will pursue this option further. At least one interviewee mentioned that problems arise when programs focus only on a "part of the patient". Certain specialized mental health and rehabilitation services were cited as examples of programs that fail to address the needs of the "total person".

X. Summary and Lessons

Michigan has had a long history of developing several different models of managed health care programs. Interviewees pointed out several lessons for other states in developing Medicaid managed care programs. First, they believe strongly that managed care is effective with Medicaid recipients. Second, communication with providers, advocates, and all other managed care participants is a key factor in the success of a Medicaid managed care program. They also emphasized the importance of the role of the advisory committee. Officials suggested establishing managed care programs slowly, due to the many interest groups and complex issues involved. They acknowledged that states differ on this issue, citing Arizona as one example of a state that implemented its managed care program relatively rapidly. However, unlike Arizona, Michigan had already created a Medicaid program when the state began its involvement with managed care. Thus, development and implementation of managed care in Michigan was more complicated from the start. Interviewees stressed that using different types of managed care models will add to the complexity of implementation. Finally, officials suggested that maintaining a separate managed care section within the state Medicaid program is a viable option when first developing a Medicaid managed care system. Although at this stage, Michigan is integrating its managed care division into the Medicaid program, they believe a special managed care division will accelerate the implementation of managed care. This may be a consideration for states attempting to expedite the creation of a Medicaid managed health care system.

Michigan believes that Medicaid managed care programs can be used to increase access to care and quality of services for Medicaid recipients, while containing costs for the state. However, the state has only limited evidence that can be used to support these claims,

particularly with regard to the SSI disabled population. Relatively few SSI disabled recipients have voluntarily enrolled in Michigan's managed care programs in the past. With the possible exception of the PSP program, the state knows little about the experience of these recipients who have been enrolled. However, Michigan officials believe that mandatory enrollment and statewide expansion of managed care plans will provide the state with more information to refine its programs for this population.

Information Resources

Interviewees - Medical Services Administration (MSA)
Michigan Department of Social Services

Darlene Born, Director, Bureau of Medicaid Operations, MSA
Mark Cohen, Senior Analyst, Managed Care Policy, MSA
Bob Christensen, Analyst-Managed Care and PSP Exceptions Officer, MSA
Gordon Duffey, Supervisor, Systems Development Section, MSA
Debbie Katcher, Analyst, Managed Care-PSP Marketing, MSA
Bill Keller, Manager, Special Programs Section, MSA
Gail Lafferty, Director, Services Review and Evaluation Division, MSA
Dr. Robert Levin, Director, Bureau of Health Services Review, MSA
Karla Marsh, Senior Managed Care Analyst, MSA
Dr. Giovannino Perri, Director, Professional Services Unit, MSA
Lorraine Potter, Analyst, Managed Care-PSP Contract Compliance, MSA
Jess Ruiz, Office Manager-PSP Processing Unit Representative, MSA
Kermit Smith, Senior Analyst-Project Director, Managed Care Entry Plan, MSA
Vern Smith, Director, MSA
Bob Stampfly, Director, Utilization Review, MSA
Judy Wilson, Manager, HMO Section, MSA

Documents

Clinic Plan Fact Sheet

History and Overview of the Medicaid HMO Program in Michigan, February, 1992

Overview of the Medicaid/PSP Program in Michigan, October, 1991

The Facts about Managed Care, September, 1992

Agreement between Michigan Department of Social Services and HMO

Physician Sponsor Plan Contract

Enrollment Data Reports for Fiscal Year 1992

Michigan 2082 Report: Fiscal Year 1992

Division One 1993 HMO Rates

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PSP County Totals, January 1992

January 1993 HMO and Clinic Plan Enrollees

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Medicaid HMO/CMP Program Review, June 1989 to August 1990

Managed Care Entry Plan materials

Michigan Medicaid Managed Care marketing materials

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State of Michigan, Department of Social Services. Medical Assistance Provider Enrollment Agreement: Subacute Ventilator Dependent Care Program

State of Michigan, Department of Social Services. Medical Assistance Provider Enrollment Agreement: Comprehensive Rehabilitation Services for Traumatic Brain Injured (TBI) Clients

Comprehensive Rehabilitation Services for Traumatic Brain Injured (TBI) Clients materials

Case Managed Home Care Services Materials

Ventilator Dependent Client Services Materials

Memorandum of Understanding (MOU) for Complex Care

Medicaid Managed Care Programs for the SSI-Disabled Population
The Case of North Carolina

I. Brief Overview of State

North Carolina's Medicaid recipients residing in 17 of the state's 100 counties have access to one of two managed health care programs. One of the programs is a fully capitated plan operated by the Kaiser Permanente HMO. On a voluntary basis, Medicaid recipients within the AFDC category only, residing in or near Durham, Mecklenberg and Wake counties, can enroll in this managed care plan. Kaiser's estimated AFDC Medicaid enrollment figure as of February 15, 1993 is between 3600-3700 individuals, about 5-10% of their total enrollment.

North Carolina's other managed care plan, Carolina ACCESS, is a mandatory program. All Medicaid recipients residing in the 15 counties in which this Primary Care Case Management (PCCM) program is located must choose a primary care physician from ACCESS' pool of participating providers. In Durham county, in which both Kaiser and ACCESS are located, Medicaid recipients have the option of enrolling in either of these two programs. Carolina ACCESS has 65,000 enrollees in 15 counties and currently engages 626 physician providers, divided among 112 group and 120 solo practices. The only exceptions from mandatory participation in Carolina ACCESS are persons in mental hospitals, skilled nursing facilities, intermediate care facilities, personal care homes, foster care, subsidized adoption or domiciliary facilities. Those persons who are dually eligible for Medicaid and Medicare have the option of enrolling in the Carolina ACCESS program. As Carolina ACCESS expands, it will establish additional mandatory choice programs. That is, if an HMO and Carolina ACCESS are both

available within a county, Medicaid recipients will have to enroll in one or the other of these programs.

The Division of Medical Assistance, a subdivision of the State Department of Human Resources, oversees the state's Medicaid program. North Carolina entitles 685,392 individuals to receive Medicaid benefits, as reflected in data reported on December 31, 1992. Of this total number, 71% (486,333 individuals) are eligible through AFDC related categories. Twenty-nine percent (29%) are eligible for Medicaid through the aged, blind and disabled categories: 37,530 SSI aged, 774 SSI blind and 54,002 SSI disabled individuals. Of those 54,002 individuals who are SSI/disabled, about 87% (46,735) receive no Medicare benefits, and about 13% (7,267) receive Medicare Parts A and B benefits. An additional 12, 478 persons are receiving Medicaid through North Carolina's Medically Needy program. These persons meet SSI disability criteria, but are over income for the SSI program. Once certified, they are eligible to receive Medicaid benefits in the Medically Needy category. However, they do not receive the cash payments usually available through the SSI program.

North Carolina is a 209(b) state, one of thirteen states in the country who have not linked SSI eligibility with automatic eligibility for Medicaid. The eligibility level for Medicaid, unchanged since 1972, is lower than for SSI. So, individuals eligible for SSI in the aged, blind and disabled categories must "spend down" their assets to become income-eligible for Medicaid. Another consequence of the state's 209(b) status is the need for applicants to go through two separate eligibility determination processes in county Department of Social Services (DSS) offices to receive SSI and Medicaid benefits. Based on data reflecting SSI enrollments on December 31, 1992, approximately 72, 150 persons receive SSI cash payments, but are not

receiving Medicaid benefits. Every year the Division of Medical Services, along with other state departments and grass roots advocacy groups, attempt to repeal the state's 209(b) status. This year another effort is underway with the state legislature to grant immediate access to Medicaid for all SSI enrollees. Tied with this initiative are recommendations for relaxing the low income limits for SSI eligibility, currently at 50% below the poverty line, to 75% of the poverty line. North Carolina's federal Medicaid match is 65%. Therefore, of the 35% paid by the state, 29% ($8.4 million) of the total increased costs ($290 million) would be the state's responsibility and 5% ($1.45 million) would fall to the counties. The remainder is federally reimbursed, the reason some think that the income limits should be relaxed.

The state's county offices are now under court order to comply with time standards for determining eligibility for SSI and for Medicaid (i.e. 90 days for SSI eligibility, 60 days for Medicaid eligibility with SSI-enrolled persons, 45 days for everyone else). Under the court order, counties will have to pay financial penalties if they exceed these timelines.

North Carolina operates several Medicaid waiver programs for adults and children whose disabilities are severe enough that they would be eligible for care in skilled nursing or intermediate care facilities. These Home and Community-Based Waiver programs enable eligible individuals to remain with family in familiar community settings, rather than being placed in an institutional setting. Carolina ACCESS also functions as a Medicaid waiver program. The state demonstrated evidence of potential cost savings with this PCCM model and received a 1915(b) waiver to enable Carolina ACCESS to operate as a mandatory managed care program within certain geographic areas of the state.

II. History of Managed Care Development in the State

The Kaiser Permanente plan, initiated in 1986, is the only capitated plan in the state serving Medicaid recipients (in the AFDC category exclusively) and covers a limited, densely populated geographic area of the state. An HMO Coordinator within the State Division of Medical Services manages and facilitates program development of Medicaid HMO programs. Once a year she asks Kaiser to expand its enrollment of Medicaid clients. Each time thus far Kaiser has declined the offer citing difficulties with staffing, funding and geographic location of office sites that interfere with serving more people or serving people with disabilities. The HMO Coordinator is trying to expand the number of capitated plans available in the state. She is currently working with two prospective HMOs (i.e. the Caroline Physician Health Plan and MaxiCare) to develop contracts with them for enrolling Medicaid clients in both AFDC and SSI categories.

Carolina ACCESS (Patient Access and Coordinated Care Program) is North Carolina's newly established Primary Care Case Management (PCCM) program . The state's investment in managed care program development began in 1984 with a joint venture with a health clinic in Wilson County employing 70 providers. Wilson County later became one of the first counties to participate in Carolina ACCESS. ACCESS began in 1988 through collaborative efforts among the state's Division of Medical Services, the Rural Health Department and the Foundation for Alternative Health Programs, supported by startup funds from the Kate B. Reynolds Health Care Trust. The grant was funded to investigate feasible managed care approaches for improving the health status of indigent populations, particularly in rural areas. Reducing health care costs was not an initial program objective. The state decided to start with the Medicaid

population, rather than attempt to address universal access for all poor persons in North Carolina, because Medicaid provided an ongoing avenue for financially supporting the program. Grant funds assisted the project with program development until 1992. As a consequence of the program's success and the advocacy of the Director of the state's Division of Medical Assistance, a legislative mandate for the state to fully fund the program was passed and approved by the Governor in 1991. As of July 1992, state and federal funds fully support the program and it has been absorbed into the state system.

The primary objectives of Carolina ACCESS are: to improve access to primary care, emphasizing continuity of care and prevention; to replace fragmentation of service with a primary care coordination system for indigent people; and to contain health care costs of Medicaid recipients. The state's most active mental health, aging and SSI disability advocacy groups have applied no resistance to the development of the Carolina ACCESS. Program developers report that this may be related to the program's objective of increasing access to primary care for the medically needy. They also noted anecdotally that Medicaid clients with disabilities who had experienced difficulty in finding a doctor are excited to have provider options from which to choose.

III. Financing and Reimbursement

Kaiser Permanente provides all the services included in the state's Medicaid package with the exception of dental care. Usual Medicaid service limits are not applicable for Kaiser's Medicaid clients. Capitation rates are jointly negotiated between the HMO and the Division for Medical Services. Kaiser creates a rate by looking at fee-for-service costs for a service package

by county, by service and by AFDC categories. They develop an average cost per recipient in each county and present these rates to Medicaid. If the rate is less than 95% of the average area per capita costs (AAPCC), Medicaid accepts it. If not, the parties negotiate to get to that level. Prior to the current fiscal year, Kaiser could purchase stop/loss insurance from the state. The state dropped this provision in negotiating this year's contract with Kaiser. One technology-dependent infant exceeded Kaiser's capitation limits a few years ago, costing the state over $1,000,000. The child eventually died. Medicaid administrators indicated that this one situation was not the precipitant for discontinuing the stop/loss insurance option with Kaiser. Rather, they felt that Kaiser, as a fully capitated plan, should take full financial responsibility for its enrollees' health care. An evaluation of Kaiser,completed 18 months ago, identified some cost savings from the program. However, these savings were needed to cover additional administrative systems' costs for the program. There have been no other evaluations.

The PCCM program, Carolina ACCESS, reimburses physicians for the medical services they provide on a fee-for-service basis. The rates are at about 90% of Medicare rates. An additional monthly care coordination fee is provided to physicians for their coordination role on behalf of the Medicaid clients enrolled with them. The following reimbursement schedule applies for all participating providers: a monthly $3.00 payment per enrollee for the first 250 enrollees, $2.50 monthly per each additional enrollee. Participating providers are responsible for providing or authorizing all of the services within the state's Medicaid package. In addition, they are responsible for after-hours coverage for primary, as well as specialist care.

As of January 1993, the state converted its rates to a Resource Based Relative Value System (RBRVS). This system effectively increases rates for primary care physicians while

decreasing rates for some medical specialties in North Carolina. Thus far, affected physicians have not reacted negatively to the change.

IV. Marketing to Enrollees

Enrollment with Carolina ACCESS is mandatory in participating counties; enrollment with Kaiser Permanente is voluntary for AFDC recipients in participating counties. Applicants for SSI and Medicaid must apply for benefits at the DSS office in their county of residence. These offices usually house a variety of human services administrative sites (e.g. Medicaid, SSI, Food Stamps, AFDC, Family Planning, Title V programs, Services for the Blind, etc.). Information about mandatory or voluntary enrollment in managed care plans in participating counties is provided to Medicaid applicants through face-to-face contact when they come in to the DSS office for initial certification and subsequent recertification visits (i.e. every six months). They can also come in at other times if they wish to voluntarily enroll. Two Kaiser Permanente Medicaid representatives are located at county DSS offices. They inform, market to and enroll AFDC clients into the program via face-to-face contacts. They use no other official marketing strategies, but do perform advocacy and outreach for clients, if necessary. For example, one of these representatives visited a recipient in her home to assist her in solving a transportation difficulty which prevented her from keeping her medical appointments.

In Carolina ACCESS counties, a Managed Care Specialist, assigned to each county, meets with the Director of Social Services for the county to keep DSS administrators updated on which doctors have signed on to the ACCESS program and to project a starting date for the county. Participating counties receive funding for a local Carolina ACCESS representative, to

be located in the county's DSS office. These representatives provide training to county DSS workers before the ACCESS program begins. The training sessions are held for twenty people at a time. About two-three weeks before the program starts up in the county, meetings are held with local hospital personnel to orient them to the new authorization processes and to enlist their support.

The local DSS ACCESS plan representative assists Medicaid recipients in choosing their primary care provider from a full list of participating physicians that is updated daily for local county DSS ACCESS representatives. Those recipients who do not choose for themselves are assigned to a provider, based on criteria developed by ACCESS and described in their approved 1915(b) waiver. The following factors are considered: residence, the client's health care history, grouping of children within the family, age and the appropriate match by provider type, given individuals' ages and gender. Exceptions to mandatory enrollment are decided jointly by field staff and the local DSS plan representative. Fewer than 10 exceptions have been made in the 15 participating counties. Examples of exceptions made include an adult with severe mental health difficulties and a child with multiple health problems. Sixty-seventy percent of Medicaid recipients in each participating county are enrolled in Carolina ACCESS. ACCESS program developers reported anecdotally that many dually eligible clients (i.e. Medicaid and Medicare) enroll in the program, especially if they are having trouble finding a doctor.

V. Provider Participation

The overall strategy of Carolina ACCESS program developers was to begin the program with five counties, add seven more and gradually expand the program across the state. Essential

criteria for county selection include: (1) commitment from county DSS administrators and (2) sufficient provider interest. They take into account whether there are enough available primary care physicians in the county or contiguous areas and enrollment slots (i.e. the number of clients each PCCM will enroll) to serve Medicaid recipients, given physician-determined enrollment limits. Physicians are able to contract for as few as one Medicaid client up to an enrollment limit of 1200 clients per physician plus 600 clients per physician assistant. Some larger practices have a limit of 40,000 clients. Many contract to serve 100-200 clients. Program developers invest considerable energy in building support with doctors and the social service community at the county level before instituting ACCESS as a mandatory program for recipients in a county. They adjust their marketing activities based on identified county level needs. For example, they have helped counties to develop a plan to increase the numbers of physicians. The final decision about a county's involvement in Carolina ACCESS is made mutually with each interested county.

To carry out this strategy ACCESS program developers spend both time and personnel resources to build positive relationships with physicians. Initially, they approached organized physician groups (e.g. North Carolina Pediatric Society) to solicit physician input at the program design stage. Program developers quickly realized that they needed to listen to and address provider complaints about past negative experiences with the state Medicaid office and with Medicaid recipients before physicians would listen to ideas about new ventures with the Medicaid program. For example, as advocates for providers, they negotiated within the Division of Medical Services to correct problems providers had with the Medicaid billing and payment systems. Program staff use a lot of personal involvement to win physician support. To establish

a presence at the county level, they send a mailing to all providers in the county, including a general letter, brochures, and a reply card. The response rate to mailings is usually about 25%. A Managed Care Specialist, assigned to each county, then phones all the physicians on the mailing list and schedules visits with them. Three or four visits to one office are sometimes required to engage a physician in the program.

Once a county has begun participation in Carolina ACCESS its Managed Care Specialist maintains extensive outreach with providers via public relations and training activities, as well as problem-solving with individual physicians. For example, they go door-to-door to engage physicians in the program. They provide training and consultation to the entire staff in physicians' offices (i.e. all participating personnel, including specialists and hospital emergency room staff) prior to and throughout a county's involvement in Carolina ACCESS. They try to rectify physicians' claims problems which delay receipt of Medicaid payments. In one situation involving an individual with complex health care needs due to disabilities, an ACCESS Managed Care Specialist developed a one person enrollment-limit contract with that person's primary care provider. This strategy had a twofold purpose: (1) to enable the client to maintain his/her connection with this provider and (2) to build in a pilot experience with the provider who was reluctant to be involved with the state Medicaid program. ACCESS staff hope that this provider's positive experience with the program on a limited basis will open up the possibilities for future expanded involvement with additional Medicaid clients.

VI. Quality of Care

Quality of care monitoring takes place through a variety of mechanisms for both the capitated and PCCM program. With respect to the capitated program, Kaiser Permanente is a federally qualified HMO, subject to utilization review, program evaluation and audits. External reviews are conducted annually by the North Carolina Peer Review Organization via random chart review of a percentage of Medicaid enrollees. Additionally, quality of care issues are monitored through examination of disenrollment patterns. In North Carolina, Kaiser Permanente may disenroll a client or a client may choose to disenroll from the plan. The HMO Coordinator reported that clients who are dissatisfied are encouraged by the Medicaid HMO Coordinator to work out the difficulty directly with Kaiser. She indicated that thus far all problems have been worked out without need for formal grievance procedures. Most quality of care issues concern referrals for specialty care and payment for out-of-plan use.

Carolina ACCESS uses multiple approaches for assessing quality of care. An 800 number, visible on program materials and brochures, is available for complaints from providers and clients. Most complaints are from hospital providers and relate to reimbursement for payment claims. Medicaid recipients who call are usually confused about the program and need information or have had trouble reaching their primary care provider after hours. ACCESS staff representatives for the county attempt to handle and resolve complaints personally with the involved parties. They are committed to responsive, non-bureaucratic approaches to maintaining positive relationships, especially with providers. They are working with a physician advisory group to develop standards of care for Medicaid recipients.

The Office of State Budget and Management carried out an evaluation of Carolina ACCESS during the past year to examine client satisfaction. The evaluators sampled perceptions of 226 Medicaid ACCESS enrollees in four counties who had been enrolled in the program for at least six months. They attempted to explore the effect of ACCESS on six dimensions of enrollees' health care status and practice: changes in their medical care routines, linkage with doctors, preventive care, satisfaction with medical information, referral/follow-up activities and compliance with medical recommendations.

Some evaluation results specific to persons with disabilities (n=86) indicate that:

1. about half of this population kept their same doctor, 24% previously had no doctor and 26% changed their primary provider when they joined ACCESS;

2. 90% were more satisfied with their ACCESS provider than with their previous medical care;

3. a majority of persons with disabilities understood the ACCESS guidelines and restrictions at the point of enrollment; and

4. 65% of persons with disabilities reported that they did not use the emergency room or outpatient services during the first six months of the year.

VII. Data

On a quarterly basis, Kaiser gives Medicaid aggregate encounter and hospitalization data. They also inform Medicaid about disenrollment incidents. The number of physician and non-physician encounters, hospital patient days, member months and enrollees provide Kaiser and

the Division of Medical Services the baseline information they need for establishing capitation rates for the upcoming year.

ACCESS is in the process of negotiating with EDS, Medicaid's Management Information System resource, about the most useful data reports for the program. At the present time they have no way to capture the service utilization experiences of enrollees who are SSI/Disabled. ACCESS wants to examine the differential practice patterns of subgroups within their enrolled population (i.e. AFDC children, AFDC caretakers and persons with disabilities). This provides some explanation for the paucity of information available about the impact of ACCESS on the population of persons with disabilities. ACCESS receives quarterly reports on each participating provider's practice patterns, listing the number of referrals for specialty care, number of outpatient visits, number of outpatient services by type, average monthly enrollment and the average monthly costs.

VIII. Utilization

Carolina ACCESS uses utilization review data to monitor service usage, and in particular, emergency room usage patterns. The state has authorized a new Utilization Review Nursing position, unfilled currently, that will focus on quality of care issues. The quarterly utilization review reports are shared with providers. In addition, ACCESS compares these figures with those of other participating physicians and with those having similar practices. They follow up individually with providers who are outliers.

Carolina ACCESS must arrange for external reviews annually under the 1915(b)(1) waiver. Such an evaluation was completed on September 15, 1992. This evaluation targeted

the first five ACCESS counties and five comparison counties. For the purposes of this evaluation, service usage patterns and costs related to three sub-groups of enrollees were analyzed and compared separately: AFDC children, AFDC caretakers and persons with blindness and disabilities. Results of this evaluation's analysis of service utilization and costs include the following: (1) total per client costs were lower for ACCESS counties; (2) costs for inpatient services decreased to a greater extent for ACCESS enrollees; (3) the costs for outpatient care/emergency room care were higher for ACCESS counties; (4) physician services, laboratory and X-ray services provided through ACCESS were smaller increases than for comparison counties; (5) growth in number of claims for outpatient and emergency room care for persons with disabilities was lower for ACCESS counties; and (6) costs for prescriptions and pharmacy services were lower for ACCESS counties. A noteworthy aspect of this evaluation is its analysis of changes in enrollees' routines regarding "doctor shopping". Results indicate that ACCESS enrollees in general had contact with fewer doctors after enrollment in the program than before. Seventy-four percent of ACCESS enrollees with disabilities had contact with two or less doctors, compared with 69% of Medicaid recipients with disabilities in comparison counties.

IX. Critical Issues

North Carolina tends to be a conservative, rural state with significant county-level interest group activity across its 100 counties. State Medicaid officials identified three obstacles to growth of managed health care for Medicaid recipients: (1) a scarcity of available physicians in rural parts of the state, exacerbated by elimination of federal funds for the Public Health

Service Corps; (2) widespread reluctance of physicians in general to serve Medicaid recipients, resulting in Medicaid consumers having to travel long distances or go to the health department to find a doctor willing to serve them; and (3) generalized resistance of health care providers and consumers to managed health care approaches. Considerable cautiousness about managed care prevails, as evidenced by its limited market penetration so far in the state. Capitated models appear to be less acceptable than PCCM models. However, a recent government audit commissioned by the legislature recommended that, in the interest of cost savings, managed care be established statewide within two years, using full capitation models. The only capitated program in the state excludes Medicaid recipients with disabilities from their plan. The state lacks information about the impact of capitated care on this population, but believes that Carolina ACCESS offers a viable alternative for serving these persons. Therefore, the Division of Medical Assistance is negotiating with the legislature to advocate for a gradual, but accelerated, expansion of the Carolina ACCESS PCCM model and to dissuade legislators from exclusive interest in full capitation models.

Administrators of both the capitated and PCCM plans identified education for all managed care participants (i.e. providers, county Department of Social service workers, MDs, Medicaid staff and clients) as essential for expansion and success of managed care in the state. People are used to "doctor shopping" and to receiving care in hospital emergency rooms. Emergency room personnel are used to carrying out their activities without prior authorization from patients' primary care physicians. Hospitals tend to worry most about the program's effect on their emergency room revenues. The Carolina ACCESS policy stipulates that emergency room use must be authorized by the Medicaid client's primary care provider. However, some

non-urgent care is still being delivered in emergency room settings. Carolina ACCESS has recently received HCFA approval to pay an assessment fee for emergency room triage services. That is, hospitals will be paid by Medicaid for their role in evaluating whether or not patients are presenting with a real emergency or are needing to be directed to their primary physician for non-urgent care. In addition, ACCESS will soon be providing each hospital with a list of emergency diagnoses and conditions they are authorized to treat without referral from the primary care provider.

Several other dilemmas face Carolina ACCESS staff related to expansion of the program statewide. Thus far, they have been working with willing counties. As they expand they will have to decide whether to move into counties with inadequate numbers of certain groups of physicians. For example, in some counties all the pediatricians have enrolled, but only a few adult providers are interested in the program. Using their well-developed and effective provider recruitment strategies, they expect to engage available providers in 60-80 of the counties in the state. They anticipate having difficulty doing this in 10-20 counties. The program may need to be voluntary in these counties. ACCESS has already begun to engage providers in contiguous counties to address physician shortages and to blend their provider options with usage patterns of Medicaid recipients who tend to cross county lines to access health care.

Finally, in relation to ACCESS' experience with persons with disabilities, adult providers for persons with disabilities have talked informally about the tremendous amount of time it takes to care for those persons, leading to concerns about enrollment limits for them. Coordination of their care takes more time. Some clients are particularly difficult for providers to serve. For example, one Medicaid client, addicted to narcotics and verbally abusive to physicians, is not

wanted by participating providers and was disenrolled by his primary care provider. ACCESS is considering putting him on regular Medicaid rather than alienate other ACCESS physicians by assigning him to another provider. ACCESS administrators are considering the development of non-traditional programs and approaches for this population, such as models in which nurse case managers could be available evenings and weekends, in an effort to reduce emergency room use after hours with these clients.

X. Lessons for Other States

The lessons learned from the experience of Carolina ACCESS offer a valuable model for other states interested in creating managed health care options. Investing time, effort and resources in building and maintaining positive relationships with providers and local social service communities were identified by all interviewees as critical ingredients in the success of the program. These strategies have contributed to improved provider relations with Medicaid in general and to provider endorsement of ACCESS in particular. While they also emphasized the need for assisting Medicaid clients to change their health care practice patterns (e.g. using the emergency room for non-emergencies and "doctor shopping"), they focused on the centrality of the role of primary providers in impacting these behaviors of their patients.

Little systematic information is available about the specific impact of ACCESS on adult persons who are SSI enrolled, limiting the state's planning on their behalf. Identification of the most critical data collection elements during the initial program development phase regarding persons with complex health, social and emotional needs seems to be an essential element for tracking program impacts. In the absence of such information and relying on informal

information channels, ACCESS is considering the usefulness of developing some specialized program options for these Medicaid consumers.

Information Resources:

Interviewees/ State of North Carolina

State Department of Human Resources, Division of Medical Assistance

Sherry Hay, Carolina ACCESS Managed Care Specialist

Denise Levis, Director, Medicaid Managed Care Division

Rosemary Long, Policy Consultant

Bo Nowell, Director of Quality Assurance

Richard Perruzzi, Deputy Director

Trekka Spraggins, HMO Coordinator

Documents

Carolina ACCESS Client Survey Study, Office of State Budget and Management, November 6, 1992

Carolina ACCESS program brochures, materials and provider contract forms

Medicaid Cost Analysis of the Carolina ACCESS Program, Management Report, State of North Carolina, Office of State Budget and Management, Sept. 15, 1992.

Medicaid in North Carolina, Annual Report, State Fiscal Year 1991, State of North Carolina, Department of Human Resources, Division of Medical Assistance

Request for Waiver for "Statewideness", "Freedom of Choice" and "Amount, Duration and Scope" under the Provisions of Section 1915(b)(1) of the Social Security Act, Carolina ACCESS, November 1989, Amended September 1990.

Medicaid Managed Care Programs for the SSI-Disabled Population
The Case of Utah

I. Brief Overview of the State

Utah utilizes three different models for delivering managed health care to its Medicaid population. First, two Utah HMOs receive a capitated payment from the state to provide comprehensive physical health services to enrolled Medicaid recipients. Utah Medicaid also has 931 fee-for-service Primary Care Physician (PCP) agreements with individual physicians, group practices or health clinics. The two HMOs operate in four urban and two rural counties within the state, while the PCP program includes all urban counties and all but three rural counties. Finally, in addition to the HMOs and PCPs, Utah provides mental health care to about half percent of the state's Medicaid recipients through a Prepaid Mental Health Plan. Medicaid contracts with three Community Mental Health Centers (CMHCs) serving ten counties to provide a wide range of mental health services. All Medicaid beneficiaries in these ten counties must receive their mental health services through the Prepaid Mental Health Plan.

Less than six percent, or about 95,000, of the state's 1.8 million persons receive Medicaid benefits. Nearly 80 percent, or 75,905, of these beneficiaries are enrolled in the AFDC/other category; 12.7 percent, or 12,065, are enrolled in the Aid to Disabled category; 7.3 percent, or 6,935, are aged; and .1 percent, or 95 individuals, are blind. The "other" category includes persons in emergency care, foster children and qualified Medicare beneficiaries. The state has limited information about the 12,065 disabled beneficiaries in the state; a consultant has been hired to compile and analyze data about this population.

About 80,000 Medicaid beneficiaries are enrolled in managed care for medical services. Approximately 20,000 are in the HMOs; the other 60,000 are enrolled in the PCP program. About 6,000 of these managed care enrollees are in the disabled category. Less than 1,000 disabled beneficiaries are enrolled in the two HMOs, the remainder are enrolled in the PCP program. Approximately 58,000 Medicaid clients are automatically enrolled in the Prepaid Mental Health Plan; about 6,000 of these individuals are in the disabled category.

Utah is a state with vast rural areas. However, 80 percent of the state's population resides along the Wasatch Front, a predominantly urban area. Currently, medical managed care enrollment in urban counties is mandatory; in rural counties it is voluntary. Medical managed care penetration is much higher in urban counties due to the mandatory status of the program and increased availability of providers. In rural areas, only 42 percent of Medicaid clients were in medical managed care in March 1992, while 58 percent of the population was in traditional fee-for-service Medicaid. However, in urban areas 83 percent of Medicaid clients were in managed care programs, with only 17 percent in the traditional fee-for-service system. Enrollment in mental health managed care is automatic for Medicaid recipients living in the ten counties where the program operates. Therefore, approximately 50 percent of Medicaid clients receive all their mental health services through the prepaid mental health managed care plan. For other Medicaid beneficiaries in the state, mental health care is fee-for-service. No mental health services are provided to Medicaid beneficiaries by HMOs.

About ten percent of Utah's clients with disabilities who receive SSI do not receive Medicaid benefits, most likely because Utah is an "SSI criteria state." In SSI criteria states, federal eligibility and application processes apply only to SSI cash benefits. The state has an

independent eligibility process for Medicaid benefits. Therefore, separate applications to different agencies are required to apply for Medicaid and SSI benefits, although the same eligibility rules apply. Interviewees thought that some clients apply only for SSI for a variety of reasons: clients may be unaware of the separate Medicaid application requirement, clients may have other health insurance, or clients may not have the energy or skills to go through both systems. Some interviewees believed that some groups of clients, particularly those with mental illness, would be content to receive the SSI cash grant and therefore, they may not apply for Medicaid coverage.

Clients without Medicaid can still obtain some services through state-operated health clinics. These clinics are staffed by 100 volunteer physicians and all care is free of charge. Adults between the ages of 18 and 65 who are not Medicaid beneficiaries can obtain services at these free clinics. The clinics provide comprehensive, acute care services, but no preventive care.

Utah's HMO, PCP and Prepaid Mental Health programs operate under 1915b federal freedom of choice waivers. The state also has about 1,500 clients with MR/DD in a home and community based services waiver program, and operates a Targeted Case Management Program under a 1915c federal waiver. Targeted Case Management is offered to persons with chronic mental illness, persons with AIDS, high-risk pregnant women, and technology dependent children.

The Division of Health Care Financing is the single state agency for Medicaid in Utah. The agency is organized around a central office located in Salt Lake City, the state capital. Local Medicaid offices are located throughout the state. The Bureau of Managed Health Care

is responsible for managed care programs within Medicaid. The Bureau of Managed Health Care is led by a bureau director who is responsible for the management of the three major units involved in managed care development: the Client Services Unit, the Health Plan/Contracts Unit and the Utilization Management Unit. Each of these units is managed by a Health Program Manager. Two divergent influences impact Medicaid in Utah. First, Utah is a conservative state where less, not more, government intervention is valued. Therefore, in order for providers to be willing to work with the state, Medicaid must behave like an insurance company rather than a government service agency. This provider attitude caused Medicaid to develop a loosely structured PCP network. In Utah's PCP program, Medicaid does not send client lists to providers; instead, consistent with traditional fee-for-service care, the provider only considers the beneficiary a member of his or her practice once the beneficiary has come to the office for health care. The state maintains limited control over the PCPs. Second, the strong Mormon Latter Day Saints (LDS) culture emphasizes sharing the burden and treating those in need. Therefore, the state medical association supports treating Medicaid clients and, some interviewees believed, particularly clients with disabilities.

II. History of Managed Care Development in Utah

During the early 1970s, the state had one HMO contract, with FHP, a staff model HMO which had evolved from an early 1970s neighborhood health center. However, in 1982 a Medicaid managed care initiative required Utah Medicaid clients living along the Wasatch Front (four urban counties -- Utah, Salt Lake, Davis, Weber -- encompassing about 80 percent of the population) to select either an HMO or a Primary Care Provider (PCP) as a case manager.

Additional HMOs were needed to contract with Medicaid to meet the new demand. During the early 1980s there was an influx of HMOs, including MedUtah, a Blue Cross HMO; and UCare, a University Medical Center HMO funded by the Robert Wood Johnson Foundation as a community health center. Medicaid became the largest single account for FHP: of 115,000 clients, 15,000 were Medicaid enrollees. Medicaid also became the largest single account for MedUtah: out of between 40,000 and 50,000 total clients, 3,500 to 5,000 were Medicaid beneficiaries. UCARE enrolled approximately 1,000 Medicaid clients. However, after one year of operation, Blue Cross began to deemphasize their HMO plan. MedUtah dropped Weber County Medicaid clients and enrollment began to decline. Currently, Blue Cross retains the MedUtah HMO as an option for Medicaid and for companies to offer employees, but it serves a limited number of clients. And in the late 1980s UCARE went out of business.

In 1986-87 the HCFA regional office in Denver suggested that Medicaid put contracts out to bid to increase the HMO penetration of Medicaid clients. However, the only respondents to the RFP were the three groups already contracting with the state: FHP, MedUtah and UCARE. Currently, the state has only two HMO contracts: FHP, a closed panel HMO, and MedUtah, an open panel IPA. HMO penetration remains a small percent of the Medicaid population. Most Medicaid clients that select an HMO are AFDC recipients and their children. Few disabled Medicaid clients choose to enroll in an HMO. The state believes that this population is already affiliated with a physician. However, if clients with disabilities select an HMO, they cannot be refused enrollment.

The PCP program in Utah also became operational in 1982. There are presently 931 PCPs who sign agreements with the state to provide primary care services and manage care for

Medicaid clients. PCPs receive no case management fee. A $2.00 per month per client case management fee was implemented January 1, 1990 but discontinued on July 1, 1991, as preliminary data indicated that the fee did not decrease emergency room or specialist utilization. As previously stated, because of the political climate of the state, the PCP program in Utah is a loose network in which any physician may participate if he or she is willing to serve Medicaid clients. Community health centers, local health departments and group practices, as well as individual physicians, osteopaths and certified nurse midwives, may serve as PCPs. The Department would prefer that clients join an HMO rather than the PCP program, as they believe the more formal structure of the HMO increases the likelihood of controlling utilization.

HMOs are fully capitated and comprehensive in the services they provide, including pharmacy and medical supplies. FHP also provides dental services, while MedUtah does not. PCPs provide primary care services and must refer clients to other providers for all specialty care. PCPs are required to provide 24 hour telephone coverage.

The HMO and PCP programs include all Medicaid recipients except those in long term care facilities for more than 30 days and share of cost clients (those individuals in need of extensive medical care who must spend a certain amount of their income each month for health care before receiving Medicaid eligibility). Medically necessary primary care services are covered for children with handicaps, including services which are directly related to any handicapping condition. However, more extensive needs must be referred to a special handicapped children's program and are not covered under the HMO or PCP program.

In addition to the HMOs and PCPs, the state received a federal waiver in 1991 to develop a mental health managed care program. Medicaid excluded mental health services from the

HMO contract in 1987 because clients were disenrolling from FHP in order to access different mental health care. The legislature initiated the mental health capitation program to improve the quality of mental health care and control Medicaid spending for mental health services. Traditionally, Local Mental Health Authorities (LMHAs) received funds from the state and Medicaid for outpatient services while Medicaid clients could also receive inpatient mental health services in general hospitals. However, under the new federal waiver program, all inpatient and outpatient Medicaid and mental health dollars are distributed to the Community Mental Health Centers (CMHCs) via a monthly capitation payment to manage the mental health care of all beneficiaries enrolled in the Prepaid Mental Health Program.

It took more than two years for the federal government to approve the mental health freedom of choice waiver. The waiver allowed the state to restrict clients' freedom of choice for inpatient and outpatient mental health care. After the waiver was approved, the Department put out an RFP for contractors to manage mental health care. Six CMHCs and one case management agency submitted applications to Medicaid. The pool of potential providers was reduced when the case management agency did not meet the criteria the state was seeking, and some CMHCs withdrew from the process because they could not agree on capitation rates with the state. Three CMHCs were finally accepted as prepaid mental health plan contractors.

The mental health managed care program covers one urban area--Salt Lake and Summit Counties, which includes about 50% of the state's population--and two rural areas. Valley CMHC in Salt Lake City is the contractor for the urban program. Southwest CMHC serves the southern part of the state, and Four Corners CMHC serves the central and eastern sections. These three CMHCs serve a total of ten counties. In these ten counties, all Medicaid recipients

are enrolled in the prepaid mental health program and must receive all mental health services from the CMHC. The only exclusions to this program are clients who are in The Utah State Hospital (for persons with mental illness) or Utah Developmental Center (for persons with mental retardation and/or developmental disabilities). When the prepaid mental health plan first became operational, Medicaid beneficiaries using psychiatric services were allowed a three month grace period to transfer from non-participating physicians, psychiatrists and psychologists to CMHC contractors. Although each of the CMHCs has the same contract with the state, implementation may differ because the supply of providers is limited in rural areas. For example, unlike urban Valley CMHC, the rural CMHCs have difficulty finding enough providers to meet demand and thus may offer a different configuration of services.

Advocacy groups for both disabled and non-disabled clients are active in Utah. The state has had few complaints from disability advocacy groups about managed care for a number of reasons: managed care has improved access to health care services, clients obtain the names of specialists through referrals from peers who have had good experiences with these physicians, disability advocacy groups tend to bring their complaints to the Division of Mental Health (DMH) or the Division for Services to Persons with Disabilities (DSPD), and exceptions to managed care enrollment are more likely to be made for disabled clients if they are requested. In fact, advocacy groups have been supportive of managed care initiatives. Utah's fee-for-service Medicaid program was traditionally restrictive in terms of psychiatric benefits. For example, until May 1993, Medicaid would not pay for freestanding psychiatric hospital care for any population. (Currently, freestanding psychiatric hospital care is available for Medicaid clients under age 21 and over age 65). These restrictions made the mental health managed care

program easy to implement since clients in the program are likely to have greater access and receive more mental health services.

III. Financing and Reimbursement

Utah's HMOs are required to provide inpatient and outpatient hospital services, physician services, lab and x-ray, prescription drugs, services for end stage renal disease (ESRD), physical therapy, hospice care, vision, family planning, podiatry, speech and audiology, medical supplies, medical detoxification for alcohol or substance abuse, home health, private duty nursing, emergency transportation, EPSDT services and some organ transplants. Not provided or covered under medical managed care are inpatient psychiatric services, ICF/MR, outpatient mental health services, care in a skilled nursing facility (SNF), personal care, institutions for mental disease (IMDs) for persons over age 65 and targeted case management. FHP provides dental care; MedUtah members have to go outside the HMO for dental services. HMOs are at full risk for all covered services. If the HMOs send people outside of their network for any covered services, the HMO retains financial responsibility. For example, although MedUtah contracts out vision care, they are responsible for covering the costs of this service in their capitation. Utah's PCPs provide primary care services and referrals to specialists. All PCP care is fee-for service and PCPs receive no case management fee.

HMO capitation rates are set annually. Capitation rates are based on PCP fee-for-service cost per eligible based on statewide experience per month for each eligibility category. The rates are adjusted by age, sex, geography (urban/rural) and aid category. There are a number of eligibility categories for both urban and rural populations: AFDC female under 21, AFDC

female 21 to 65, AFDC male under 21, AFDC male 21-65, Disabled female, Disabled male, aged, medically needy child, medically needy adult, pregnant woman, blind. Capitation rates are calculated for each service package and aid category. The average HMO rate is 90 percent of the typical PCP cost per eligible; the average PCP cost per eligible is 87 percent of the traditional fee-for-service cost per eligible.

Utah does not have an SSI disabled capitation rate; there is a rate for all disabled clients. Rates differ substantially for the AFDC and disabled populations. For example, in FY 1992, the FHP rate for AFDC adult males was $158.35, for AFDC adult females it was $152.02. For disabled males, the rate was $207.91; for disabled females it was $224.88. The aged rate was $152.86, while the blind rate was $110.66. MedUtah's capitation rates were comparable to FHP's, with an adjustment made for excluding dental services.

HMOs are protected from catastrophic costs through a $15,000 stop-loss reinsurance policy for hospital care only. The HMO and the state share the risk for high cost cases. If an individual claim goes over the stop-loss limit, the state pays 80 percent of the cost, while the HMO is responsible for the remaining 20 percent. The HMO also keeps any surplus of up to six percent. Medicaid receives 80 percent and the HMO 20 percent of any additional surplus. There is no risk for the PCP. Therefore, the state would prefer that clients enroll in HMOs. Interviewees indicated that because HMOs had financial incentives to control utilization they were a better risk than the PCP program.

All mental health services for Medicaid recipients in the ten counties participating in mental health managed care must be provided by the contracting CMHC. Mental health services for clients in other counties are fee-for-service, even if the client is an HMO member. Included

in the mental health capitation rate are inpatient psychiatric and related psychiatrist services, targeted case management (TCM) for persons with chronic mental illness, evaluation, psychological testing, individual and group therapy, medication management and day treatment.

Risk is managed differently in the prepaid mental health plan than in the HMOs. The CMHCs are prepaid for clinic services but are not at risk for those services in the first two years of the program; they are at full risk for inpatient services. During year three of the mental health waiver (July 1, 1993 to June 30, 1994) the CMHC will be at full risk for all inpatient and clinic services. Clinic services include the Medicaid rehabilitation option and TCM, as well as physician and psychologist services. The CMHCs were comfortable managing the inpatient costs early on, but were not sure about costs for outpatient care because new services had been recently added that were not in the database used for rate setting. Phasing in risk allowed the Department to obtain baseline data on which to base reasonable capitation rates for these services.

There are ten prepaid mental health rate categories, similar to the HMO rate categories, covering every Medicaid eligible except those in the state hospital or the developmental center. The disabled rates include persons with chronic mental illness. To determine rates the state calculates expenditures by aid categories, and then by eligible months. In the mental health capitation plan, as in the HMOs, the premium is considerably higher for disabled clients. For instance, Valley CMHC's rate is approximately $52.00 for AFDC clients and $167.00 for disabled clients.

At the time of our site visit, the state did not yet know whether mental health managed care had been cost effective, however they believed it had given them an opportunity to control

funds and individualize services. However, more recently,in making their waiver renewal request to HCFA, they were able to gather data suggesting that during the first two years of the prepaid mental health program in the risk portion of the contract, cost effectiveness was demonstrated through a slowdown in the overall growth of expenditures for mental health services, a decrease in the number of inpatient psychiatric days worth about $1.5 million, and a savings of approximately $1.8 million when comparing what Medicaid would have paid providing the same services that were provided on a fee-for-service basis. The state also has data suggesting that medical managed care has been cost effective. HMOs are ten percent less costly than PCPs, which have been about 13 percent less costly than traditional fee-for-service. The state currently has no data available about specific savings for disabled populations.

IV. Marketing and Enrollment

Enrollment in Utah's HMOs and PCP program is mandatory for all Medicaid recipients in urban areas where managed care is offered. Although the state encourages enrollment in Medicaid managed care plans, enrollment is voluntary in rural areas due to a more limited number of managed care providers. The mental health managed care program is mandatory in both the urban and rural areas where it is exists.

Marketing medical managed care to potential enrollees is the primary responsibility of the Department, which provides a toll free Medicaid information line and reviews all HMO marketing materials. However, the amount of marketing is limited since PCPs generally do not market themselves. Moreover, there are only two HMOs in the state that contract with Medicaid, and MedUtah does not make strong efforts to enroll the Medicaid population.

Health Program Representatives (HPRs) are primarily responsible for medical managed care enrollment. The HPRs make managed care presentations at local family support offices when clients apply for Medicaid. Beneficiaries view a videotape about Medicaid, managed care options, emergency room use, EPSDT and family planning. They are given a managed care enrollment form and a brochure explaining benefits. The HPR assists in the choice of a health plan option. If a client does not choose a managed care provider at the initial HPR meeting, he or she must call or send the HPR the name of his or her choice. Adults who do not choose a provider are not assigned to one; rather, they are not sent a Medicaid card. Children who do not choose a provider are assigned to a provider with whom they have had a previous relationship, based on claims data. If the child does not have a previous relationship with a provider, assignment to FHP is made and a letter is sent notifying the client that he or she has ten working days to reject the assignment by selecting another provider. The state sends a list of clients to the HMO on a monthly basis; PCPs receive quarterly lists. However, the PCP only considers someone a client once he or she has come in for care. The CMHCs providing services through the prepaid mental health plan do no marketing. Enrollment is mandatory and clients have no choice of CMHC. Individuals who use no CMHC services are still considered prepaid mental health plan enrollees.

There are some exclusions to mandatory status in both the medical and mental health managed care programs. HPRs have the authority to make exceptions to mandatory enrollment in the HMOs and PCP program. Some interviewees indicated that it is more likely that a person with a disability would receive an exemption from managed care, except for the mental health plan. These exceptions may be made because a beneficiary has a previous relationship with a

specialist, because a very specific service is required, or to spare the PCP from having to make extensive referrals. These interviewees suggested that very ill clients are more appropriate in the traditional fee-for-service system because they require a great deal of care, and few PCPs want the responsibility of making numerous referrals. However, if an ill client wants to join a managed care plan, no discrimination based on health status or needs is allowed. HMOs and PCPs do no prescreening. Fewer exceptions are made to the prepaid mental health plan; rather than making an exception to mental health managed care, clients will be granted a transition period.

Interviewees felt that, in general, Utah providers are sensitive to people with disabilities and are willing to care for them. This is considered related to the Latter Day Saints' influence. However, most of the clients with disabilities in medical managed care enroll in the PCP program. Few disabled clients enroll in HMOs. Ninety percent of HMO enrollees are AFDC, only five percent of HMO enrollees have disabilities. The majority of SSI recipients that participate in managed care in the state are enrolled in the PCP program. However, on the mental health side, interviewees believe that a large percentage of clients receiving ongoing managed mental health care services from the CMHCs are in the disabled category.

V. Provider Participation

Utah has a total of 5,307 fee-for-service providers who accept Medicaid. There is a 22:1 ratio of Medicaid recipients to physicians in the state. Interviewees felt that there was a sufficient number of physicians in most areas of the state, although a few rural areas such as Utah County have fewer providers who accept Medicaid. Therefore, there may be a physician

shortage for Medicaid clients in those areas. The state has more difficulty encouraging Medicaid participation by dentists.

As described previously, two Utah HMOs and 931 PCPs provide managed health care services to Medicaid recipients. Three CMHCs provide managed mental health care services to Medicaid recipients. Intermountain Health Care, Intergroup of Utah, United Healthcare and Cigna have expressed interest in developing HMOs and participating in Medicaid managed care. At the time of our site visit interviewees anticipated that some new HMOs would begin enrollment this year, resulting in an increase in HMO enrollment of ten to fifteen thousand. Currently, Medicaid clients are about 10 percent of FHP's enrollment, but represent far fewer of MedUtah's clients. Interviewees thought that if Medicaid put any pressure on them to increase enrollment, MedUtah would drop their Medicaid contract. The department has a particularly good relationship with FHP and is looking to develop that type of relationship with more commercial HMOs. The department also has a strong relationship with the three CMHCs participating in mental health managed care and is looking toward expanding the prepaid mental health program in the future.

PCPs include a number of specialties in Utah: General Practice, Family Practice, Internal Medicine, Obstetrics and Gynecology, Pediatric, Osteopathy and Midwifery. Group Practices, Community Health Centers and Local Health Departments can also serve as PCPs. Seventy-five to 80 percent of primary care providers in the state accept Medicaid clients. The 931 PCPs manage the care of between one and 1856 Medicaid clients. Physicians are seeing Medicaid clients in part due to the aforementioned cultural influence of the LDS church. Most physicians' practices include about ten percent Medicaid clients. However, many practices are

no longer accepting new patients. This is a concern for future managed care expansion. Provider sources for new clients are dwindling, and the community health centers are full. For new Medicaid clients without a PCP affiliation, enrollment in an HMO is the only viable alternative.

In the PCP program, primary care physicians must make referrals for all specialty care. If a specialist does not have a referral from the PCP, but treats a Medicaid client, he or she may receive no reimbursement. Specialists participate in Medicaid because they prefer not to anger primary care physicians, **and because they are guaranteed payment.** However, Medicaid reimburses physicians at a rate that is about 50 percent of typical charges. Primary care physicians receive an additional ten percent in urban areas and an additional twelve percent in rural areas. For an average primary care visit, the state pays $20.00. Pediatricians are paid at a higher rate, about 63 percent of typical charges.

Providers in managed care cannot refuse to serve any Medicaid client. However, in the HMOs the plan is allowed to assign clients to primary care physicians with a specialty. Therefore, disabled recipients may see a limited number of HMO primary care physicians who are consistently assigned to or chosen by this population due to reputation, interest or experience. Since the majority of both Medicaid clients and persons with disabilities are in the PCP program, PCP providers are the providers with the most extensive experience serving clients with disabilities.

PCPs may prefer not to care for the lock-in group, Medicaid abusers. These clients are limited to one physician and pharmacy, often as a result of the overuse of prescription medication. Some physicians do want to manage this group, however, as they prefer to be

able to control their service use. Last year the department asked FHP to manage the entire lock-in group, approximately 300 beneficiaries. FHP refused, stating, "You couldn't pay us enough."

The state receives few complaints from providers. Provider satisfaction issues with Medicaid are not isolated to managed care or to clients with disabilities. In fact, no interviewee recalled a specific incident of a provider complaint about a client with a disability. Rather, the frustrations of physicians revolve around low Medicaid payment rates and the administrative burden of Medicaid, including referrals and slow payment. As a result, the Department has upgraded its claims processing; taking only six days to process and pay a claim.

VI. Quality of Care

Utah uses several monitoring activities to ensure access and quality in its Medicaid managed care plans, including ongoing monitoring by the state and Utah-Nevada Peer Review Organization (UPRO) through a retrospective review of services provided, prior authorization program, HPR tracking of recipient complaints, and UPRO quality assurance reviews of HMO case records.

HMOs are required to have an enrollee grievance system, and must act upon enrollee grievances within 45 days. Any complaint is channeled first to the HMO or PCP, then to the HPR. If the HPR cannot resolve the complaint, it goes to the Department. Copies of all formal grievances are forwarded to the Department for review. Most complaints about the HMOs regard the length of time it takes to get an appointment for routine care (all calls are screened to determine urgency), while the complaints about the PCP program involve the inability to

access a primary care physician. The CMHCs have their own grievance procedures. Most CMHC complaints have involved the limited choice of providers. However, the state has received few complaints about managed care from beneficiaries. Interviewees could not recall a specific grievance coming from a disabled enrollee.

Interviewees suggested that treating a commercial population helps to ensure quality in the HMOs. All HMOs that contract with the state must be federally qualified. Each HMO has a written quality assurance plan--FHP's is particularly sophisticated. So far, UPRO and state reviews of both the HMOs and PCPs indicate good quality and access, at least comparable to the traditional fee-for-service system. Any quality problems are thought to be isolated, not systemic.

The state works to resolve enrollee complaints rather than have the person disenroll from managed care. Clients can change providers at any time. However, clients who have mandatory enrollment and choose an HMO must wait 30 days before disenrolling. PCP clients who change providers too often may be considered abusers and targeted for the lock-in program. The most common reasons clients change primary care providers include the provider being too busy and refusing to serve the client, the client or provider moving, complaints about quality, or a pregnant client preferring that her primary care physician be an obstetrician. Clients who do not have mandatory managed care status can disenroll from the program at any time. However, most clients appear satisfied with the program. Between July 1, 1989 and June 30, 1990 there were only 89 voluntary terminations from managed care. Most of these persons were terminally ill clients seeing specific specialists, individuals with multiple handicaps, or beneficiaries in rural counties who had to travel a great distance to obtain care. The Department is working to

develop better outcome and performance quality measures. Interviewees believe that quality is higher in managed care than in the fee-for-service system because beneficiaries have increased access, physicians in managed care are reviewed and audited more closely, and UPRO provides technical assistance by physicians to resolve difficulties.

In the prepaid mental health program, the Department is involved in contract monitoring and quality assurance. Although it is too early to determine quality outcomes, the general attitude from providers and the Department is that more centralized, flexible funding leads to increased quality. Some of the quality measures they are using in this program are number of readmissions, average length of stay in residential and supported housing, and case management data on satisfaction, independence and symptomatology. Jon Christianson, a researcher from the University of Minnesota, is examining Utah's prepaid mental health program as part of a quality, cost effectiveness and access study with special emphasis on adults with schizophrenia.

VII. Utilization of Services

Utah's managed health care plans are responsible for managing the service utilization of enrolled Medicaid recipients. The Department and UPRO provide technical assistance to the plans as needed. In the HMO, utilization is managed in several ways. Each HMO must have a written utilization monitoring plan. HMO reports are reviewed by the Department semiannually to examine their utilization process. The Department studies operating costs, number of eligibles and units of service. These reviews have indicated that HMO membership has led to decreased hospital utilization but increased physician utilization. UPRO also has a contract with the state to review HMO case records. Their utilization management unit

retrospectively reviews the medical records of 100 percent of hospital outliers and concurrently reviews any hospitalization over 30 days.

In the HMOs, primary care providers must approve referrals to out-of-plan providers for services for which the HMO is responsible. Clients are responsible for contacting the HMO if emergency care is required. In grave emergencies, if a client goes directly to the emergency room, he or she must contact the HMO within 48 hours. Clients learn about the process of obtaining care through a required educational process led by HMO staff. If a client does not attend the mandatory educational process, he or she is disenrolled from the HMO and must choose a PCP. The primary care physician, usually the case manager in the HMO, is responsible for utilization control.

In the PCP program, techniques used to control utilization are referral, prior authorization, case management, post-payment reviews and the lock-in program. A signed referral form is required for all specialty or inpatient care. The referral must be in the system for payment. The state has developed a system of linking claims from specialists with referral forms. Prior authorization by the Department is required for certain surgeries, inpatient psychiatric care, home health care and other elective services. No referral or prior authorization is required for emergency room visits or family planning. However, the state has a triage policy to discourage overutilization of the emergency room. Hospitals are paid only $20.00 for emergency room visits that the Department deems not true emergencies. The PCP serves as the case manager for clients in the program; the name of the PCP is imprinted on the Medicaid card.

Some interviewees had concerns about the effectiveness of utilization management in the PCP program. The Department believes that there may be an overconsumption of services by PCP clients, particularly the use of emergency rooms by children at night. One interviewee indicated that PCPs are aware of only about 75 percent of services used by their patients. Prior attempts to control utilization have not produced desired results. For example, the Department stopped paying a case management fee because it did not affect emergency room or specialist utilization. New utilization control mechanisms under consideration include further education of parents and primary care providers.

In the mental health managed care program, utilization is managed through a three level case management program for persons with chronic mental illness. First, all persons with chronic mental illness receive case management services by their primary therapist. Second, a subgroup of this population receives acute case management for 30 to 60 days as needed. Third, another subgroup of the most needy clients receives ongoing targeted case management (TCM). The severity, history and chronicity of the illness, as well as current functioning determine eligibility for TCM. Clients without chronic mental illness do not receive case management services; however, the CMHC controls service utilization through an internal utilization review system.

For clients residing in counties where the prepaid mental health plan is operational, there is no DMH case management; all case management is done through the provider agency. DMH does operate a case management program for clients who reside in other counties. DMH's program is targeted to clients with chronic mental illness and other high users of mental health services. The Division of Services for Persons with Disabilities (DSPD), which serves clients

with mental retardation/developmental disabilities (MR/DD), other cognitive disorders, and a wide range of physical disabilities, also has its own case management program. Clients with MR/DD or physical disabilities can choose to receive case management through DSPD. These state case managers are responsible for the coordination of all support services.

Clients in the prepaid mental health plan or the DMH or DSPD case management programs may also belong to an HMO or the PCP program. However, there is minimal coordination of physical health services, mental health services, and support services. Clients enrolled in both medical and mental health managed care may have two separate case managers with no link between them. Clients in the DMH or DSPD case management program may also have two case managers if also enrolled in medical managed care.

The Department cannot provide utilization information for each of the groups of clients with different types of disabilities, and is just beginning to identify their high cost clients. The Division of Family Services is studying the HMO records of children with mental and physical disabilities and women with high risk pregnancies to try to determine service utilization and costs. The state does not specifically target high cost clients, but does sponsor specific case management programs for persons with chronic mental illness, pregnant homeless women, foster children, technology dependent children, and EPSDT eligible substance abusers.

VIII. Data

Utah's Medicaid program does not receive person specific data for clients enrolled in HMOs. Person specific data are in the Medicaid claims system for PCP clients. For PCP clients, the Department prepares a summary of eligibles each month by aid category, and reports

of expenditures by service by county, aggregate expenditures by county, and aggregate data by aid category for each service. The Department obtains other data from the system as needed, for example, to generate reports on exceptional recipients by dollars to target them for the lock-in program.

The HMOs provide the state with aggregate utilization and financial reports on a quarterly basis, an annual disclosure statement and state insurance report, and every six months provide encounter data, a table of Medicaid enrollment by aid category, aggregate cost data by aid and service category, and aggregate utilization data by aid and service category. In addition, each year the HMOs provide information on all Medicaid deliveries by mother and baby by type of service and service cost. All low birthweight and prenatal hospital admissions, and all immunization data are reported by the HMOs for the EPSDT program.

For the first two years of prepaid mental health program, the contractors have provided the Department with fee-for-service data in the form of shadow claims. This information is person specific data similar to the data within the Medicaid claims system. Interviewees reported that the Department plans to continue requiring this detailed data until they determine how to collect useful information in a less cumbersome form.

IX. Current and Future Issues

The Department plans major managed care expansion through three different initiatives. First, they would like to increase HMO contracting. Second, they plan to expand the mental health managed care program. Finally, they intend to modify the mental health managed care model and capitate for other services such as pharmacy. The Department's philosophy is that

capitating services is more effective than carving out populations because it is less stigmatizing and costly for all clients to utilize the same system.

The state is trying to address the bias of HMOs against Medicaid. HMOs say the Medicaid capitation rates are not high enough and the population is difficult to serve. However, HMOs are a critical feature of health reform efforts planned in Utah and the Department is working to increase their participation in Medicaid. Currently, Intergroup of Utah, United Healthcare, Cigna, and Intermountain Health Care (IHC) are developing HMO plans that will contract with the state. IHC is considering penetrating the rural areas because they own hospitals throughout the state. Interviewees suggest that if all contract, these new HMOs will increase Medicaid managed care enrollment by 20,000 to 30,000.

Interviewees believe that if providers view Medicaid as just another insurance company, they will be more likely to become contractors. However, too few commercial HMOs have been willing to participate, and two or three new HMO contracts will not be enough to serve all clients. The Department is working on solutions. Although the Department would prefer to increase the number of HMOs, another option is to contract with more PCPs. However, a more structured system would be preferred. The Department has considered a modified PCP program with primary care managed by a utilization management agency that would authorize all referrals.

The effectiveness of the prepaid mental health program over time needs to be determined. Mental illness is a major Medicaid expense. The Department is interested in studying inpatient hospital admissions, length of stay, impact of new services and recidivism rates, particularly among individuals with schizophrenia. Interviewees expect the prepaid mental health program

will increase access to care, ensure the provision of high quality services, and decrease the cost of treating mental illness.

The number of Medicaid clients with disabilities is growing fifteen percent each year in Utah. The state suspects enrollment continues because rehabilitation of persons with disabilities is not supported. Many disabled clients on Medicaid are addicted to substances, have back injuries, or have acute mental illness. A large percentage of these individuals could participate in some form of rehabilitation, but rehabilitation efforts are not required. The Department would like to design a program with a mandatory rehabilitation component for appropriate clients.

Interviewees expressed comfort with the state's current practice of integrating special populations in their managed care programs. Utah considers its special populations to include persons with disabilities, particularly those with serious mental illness; persons with addictive disorders; substance abusing pregnant women, especially those who are also homeless; handicapped children; persons with AIDS; and frail elders. Rather than excluding these populations from mainstream managed care, interviewees believe HMOs should be paid an appropriate rate to care for them. In addition, the Department supports carving out packages of services to ensure that special populations are adequately served. Interviewees thought the state needed to work to better define disability and determine how to best provide and coordinate medical and support services for this population.

X. Summary and Lessons

Although Utah has only been involved in Medicaid managed care efforts since the early 1980s, the state has been innovative in program development. State officials believe that Medicaid managed care programs can be used to increase access to and quality of services for Medicaid recipients, and contain costs for the state. Medicaid officials also believe that further development of managed care plans, particularly plans that capitate specific service packages, will give the state more information to refine its programs. Thus far evidence supports the claim of cost-effectiveness, and suggests that access and quality are at least as good as in the traditional fee-for-service system. The state has no data specific to the experience of disabled recipients in managed care, however.

Interviewees pointed out some lessons for other states in developing managed care programs for Medicaid clients. First, they suggested capitating services and not excluding certain groups of clients. HMOs are based on the medical model and are not set up to provide the social and behavioral supports often needed by individuals with disabilities. Officials believe that most HMOs are not ready to adequately serve all the needs of special populations, but do adequately serve these clients medically. Enrolling clients in HMOs for medical care and in other capitated programs for support services is a method for confronting this issue and ensuring clients receive the services they need. Second, they believe it is critical to develop good working relationships with providers and for providers to work with Medicaid as they would any other insurer. Finally, officials suggested it is important for states to develop an understanding of the disabled population in their state, and to develop appropriate rehabilitation programs as a method for containing costs.

Information Resources

Interviewees - Utah Department of Health, Health Care Financing Division

Rod Betit, Director

Barbara Christenson, Health Program Manager

Michael Deiley, Eligibility Coordinator

Roy Dunn, Data Manager

Patti Fuhriman, Health Program Representatives Supervisor

Ed Furia, Director, Bureau of Managed Health Care

Joan Gallegos, Health Program Manager

Gail Rapp, Health Program Manager

Zorheh Speckman, Health Program Manager

Documents

FHP Summary of Costs and Rates, December 31, 1991

Mental Health Managed Care Plan Description

Freedom of Choice Waiver Renewal for July 9, 1991 to June 30, 1993

Annual Statistical Report of Medicaid and Utah Medical Assistance Program, FY 1991

Annual Statistical Report of Medicaid and Utah Medical Assistance Program, FY 1990

Utah Department of Health Organizational Chart

PCP Provider Listing, October 1, 1992

Model HMO Contract

FHP Utilization Data, January 1, 1992 to June 30, 1992

Medicaid Eligibility Data, January 1, 1991 to December 31, 1991

Mental Health Managed Care Waiver Application, September 15, 1988

Response to HCFA Regional Office's Compliance Review of Freedom of Choice Waiver, July 15, 1991

Health Program Representative Job Description and Qualifications

"Stepping Stones to Medicaid Benefits"--Enrollment Brochure

Report on Terminations from Waiver by District, July 1, 1989 to June 30, 1990

Utah-Nevada Peer Review Organization Quality of Care Report, December 19, 1989

Peat-Marwick Evaluation of Freedom of Choice Waiver, April 15, 1991

APPENDIX B

Survey of Administrators
Medicaid Managed Care Health Plans for the SSI Disabled

The Institute for Health Policy at Brandeis University is examining the use of Medicaid managed care programs to serve working-age persons with disabilities. The National Academy for State Health Policy and the World Institute on Disability are also participating in this project, which is funded by the Health Care Financing Administration.

To improve the information base for health plan administrators, state Medicaid programs, and the federal government, Brandeis is conducting a survey of administrators of all health plans known to be serving this population. In this survey, we address a variety of issues that health plan administrators may experience in overseeing managed care health plans which enroll adults who are disabled and eligible for Supplemental Security Income and Medicaid benefits.

Thank you for agreeing to participate in this survey.

PLEASE DO NOT MAIL THIS SURVEY BACK TO BRANDEIS. We are mailing this questionnaire to you in advance so that you have an opportunity to review the questions and determine the answers. An interviewer will call you within the next two weeks to schedule a call and collect your answers. Please complete as much of the questionnaire as possible before the call. If the information cannot be obtained, write a DK (Don't Know) next to the question.

Thank you for taking time to complete this questionnaire. Your assistance is most valuable and can affect state and national policies directed to improving the ability of managed care plans to provide high quality cost-effective services for the SSI disabled population. The confidentiality of the information you provide will be carefully protected. If you need assistance in completing this questionnaire or have questions, please place a collect call to Mari-Lynn Drainoni, Project Manager, at the SSI Survey Assistance Hotline, Brandeis University, (617) 736-3921.

Public reporting burden for this collection of information is estimated to average .75 hours per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Health Care Financing Administration, P.O. Box 26684, Baltimore, Maryland 21207-5187, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503. Paperwork Reduction Project (0938-0621).

I. MANAGED HEALTH CARE PLANS: ORGANIZATIONAL DATA

In this section of the questionnaire, we would like to know about the organization and structure of your managed care plan. We are also interested in enrollment data.

A. Plan History

A1. We are interested in understanding how the decision was made to enroll SSI disabled adults in your plan. Please indicate whether each of these reasons was VERY IMPORTANT, SOMEWHAT IMPORTANT, NOT VERY IMPORTANT, or NOT AT ALL IMPORTANT in your plan's decision to enroll the SSI disabled. (%)

Reason for Enrollment	Very Important	Somewhat Important	Not Very Important	Not At All Important	Don't Know	N/A
1. Managed care services were requested by SSI disabled adults or their families	16.3	11.3	15.0	33.8	20.0	3.8
2. Health care providers within the plan requested services on behalf of SSI disabled adult client	7.5	17.5	16.3	35.0	20.0	3.8
3. Advocacy groups lobbied the plan for services for SSI disabled adults	2.5	7.5	12.5	47.5	25.0	5.0
4. The state mandated that the plan serve SSI disabled adults	70.0	8.8	3.8	8.8	6.3	2.5

* The number of respondents equals 80 unless otherwise specified.

Reason for Enrollment	Very Important	Somewhat Important	Not Very Important	Not At All Important	Don't Know	N/A
5. The plan wanted to increase enrollment	20.0	18.8	12.5	38.8	7.5	2.5
6. The plan wanted to better manage costs for this population	35.0	16.3	8.8	28.8	8.8	2.5
7. The plan wanted to better manage utilization of services for this population	37.5	12.5	10.0	28.8	8.8	2.5
8. The plan wanted to improve coordination of services for this population	35.0	17.5	8.8	28.8	7.5	2.5
9. The plan wanted to better organize referrals to specialists for this population	28.8	18.8	11.3	30.0	8.8	2.5
10. The plan had other reasons (Please specify)	15.0	0.0	1.3	7.5	6.3	2.5

Group is underserved
County already serving them FFS
Set up as a research project
Commitment to community service

* The number of respondents equals 80 unless otherwise specified.

A2. As of December 31, 1992, how many years had this plan been providing managed care services?

n=79, mean=10.2 years

A3. As of December 31, 1992, how many years had this plan been providing managed care services to any Medicaid recipients?

n=79, mean=7.4 years

A4. As of December 31, 1992, how many years had this plan been providing managed care services to adult Medicaid recipients in the SSI disabled category?

n=75, mean=6.8 years

A5. Have you incurred additional capital costs for any of the following items so that you may serve the SSI disabled population? Please check all that apply. (%)

Item	Within the last 12 months	Ever	Both	Do Not Know	Missing
Ramps	7.5	20.0	0.0	2.5	70.0
Elevators	3.8	11.3	0.0	2.5	82.5
Bathrooms	8.8	17.5	1.3	2.5	70.0
Communications Devices	2.5	13.8	3.8	2.5	77.5
Other 3.8	2.5	2.5	2.5	88.8	

(Please specify)
Motorized wheel chairs and scooters
Braille signage
Hospital beds
Walkers, parking

* The number of respondents equals 80 unless otherwise specified.

B. Organization and structure of the plan

B1. Does the state mandate enrollment in a MC plan for the SSI disabled population? (%)

55.0 1. No

42.5 2. Yes

1.3 3. Do not know

1.3 4. Missing

* The number of respondents equals 80 unless otherwise specified.

B2. Please indicate plan type. (%)

8.8 1. HMO -- Staff Model

7.5 2. HMO -- Group Model

10.0 3. HMO -- Network Model

21.3 4. Independent Practice Association (IPA)

15.0 5. Primary Care Case Management Program (PCCM)

3.8 6. HIO -- Health Insuring Organization

0.0 7. County Health Center

3.8 8. Clinic Plan

5.0 9. Other

8.8 CMHC

5.0 Mixed HMO and IPA

7.5 Mixed HMO

1.3 Mixed PCCM and HMO

1.3 Other Mixed

1.3 Missing

B3. Can clients obtain all primary and specialty medical services at one site? (%)

77.5 1. No

12.5 2. Yes

8.8 3. Both

1.3 4. Missing

* The number of respondents equals 80 unless otherwise specified.

B4. Could you tell us who owns your plan? (%)

3.8 1. Blue Cross/ Blue Shield

2.5 2. Commercial Insurer

8.8 3. National HMO Company

7.5 4. Provider-sponsored

30.0 5. Independent

46.3 6. Other -

1.3 7. Missing

B5. Please indicate tax status. (%)

33.8 1. For-profit

63.8 2. Non-profit

2.5 3. Missing

* The number of respondents equals 80 unless otherwise specified.

B6. Which of the following best describes the structure of the medical network in your plan used by most of your plan enrollees? Please check only one answer. (%)

12.5 1. Solo physicians or partnerships

8.8 2. Groups of 3-7 physicians

1.3 3. Groups of 8-15 physicians

6.3 4. A single large multi-specialty group practice

2.5 a. alone

3.8 b. with other arrangements

26.2 5. Combination (Please specify)_____
Combination of solo and small groups
Solo, Groups of 3-7, Groups of 8-15

0.0 6. Groups of 16 or more physicians

45.0 7. Missing

B6.1 Is this a single or multi-specialty plan? (%)

18.8 1. Single specialty

80.0 2. Multi specialty

1.3 3. Missing

* The number of respondents equals 80 unless otherwise specified.

B7. Number of Enrollees. Please indicate your last 12 month reporting period ending 12-31-92. Report the numbers from your last 12 month reporting period for each of the following questions.

	Mean Numbers, last 12 month reporting period
1. How many total enrollees did your plan serve? n=77	128,418
2. How many Medicaid enrollees did your plan serve? n=77	27,086
3. How many AFDC enrollees did your plan serve? n=69	21,958
4. How many SSI disabled adults did your plan serve? n=67	1,966
5. What was the average number of outpatient visits (physician and other) per enrollee for your AFDC clients? n=29	7
6. What was the average number of outpatient visits (physician and other) per enrollee for your SSI disabled adult clients? n=30	10

B8. Are these numbers based on records or estimates? (%)

58.7 1. Records

28.8 2. Estimates

7.5 3. Both

1.3 4. Do not know

3.8 5. Missing

* The number of respondents equals 80 unless otherwise specified.

B9. Do you have an upper limit cap on the number of Medicaid recipients enrolled in your plan? (%)

47.5 1. No

50.0 2. Yes (Please specify) mean=26,808

1.3 3. Do not know

1.3 4. Missing

B10. Do you have an upper limit cap on the number of SSI adult disabled Medicaid recipients enrolled in your plan? (%)

82.5 1. No

15.0 2. Yes (Please specify) mean=208

1.3 3. Do not know

1.3 4. Missing

B11. Provider Characteristics. Please use information from your last 12 month reporting period to filling the appropriate numbers for each of the following questions in Columns 1 and 2.

	1 Total Numbers	2 Numbers of Full Time Equivalents
1. How many physicians were practicing in your plan?	mean=914 median=175 n=73	mean=299 median=10 n=29
2. How many of these physicians served as primary care physicians?	mean=270 median=40 n=72	mean=93 median=10 n=36
3. How many nurse practitioners, physician's assistants, and nurse midwives were practicing in your plan?	mean=55 median=3.5 n=58	mean=14 median=2 n=38

* The number of respondents equals 80 unless otherwise specified.

B12. Are these numbers based on records or estimates? (%)

60.0 1. Records

28.8 2. Estimates

3.8 3. Both

7.5 4. Missing

II. DEMOGRAPHICS AND CLIENT SATISFACTION

In this section of the questionnaire, we would like to know about the demographic characteristics of the SSI disabled population you serve and your methods of assessing client satisfaction.

A. Population Characteristics

Using data from December 31, 1992, please report the following information about the actual number of SSI DISABLED CLIENTS over 18 enrolled in your plan. Please report the actual number of clients in Column 1. If you are unable to obtain this number, please give an estimated percentage of total enrollment in Column 2.

A1. RACE/ETHNICITY OF CLIENTS	1 Mean Numbers on Dec. 31, 1992	2 Estimated Percentage of Total Enrollment
1. White, not Hispanic	59.1 n=10	43.6 n=22
2. Black, not Hispanic	23.9 n=11	18.0 n=21
3. Hispanic	16.5 n=11	36.2 n=22
4. Asian or Pacific Islander	1.0 n=10	1.3 n=19
5. American Indian or Alaskan Native	1.1 n=9	1.9 n=20
6. Other (Please specify) Russian Armenian Arab	258.3 n=9	0.8 n=17

* The number of respondents equals 80 unless otherwise specified.

A2. GENDER OF CLIENTS	1 Mean Numbers on Dec. 31, 1992	2 Estimated Percentage of Total Enrollment (%)
1. Female	744.3 n=27	62.8 n=29
2. Male	551.9 n=26	37.2 n=29
3. Missing	_____	_____

A3. AGE OF CLIENTS	1 Numbers on Dec. 31, 1992	2 Estimated Percentage of Total Enrollment (%)
1. 18-24 years old	34.8 n=17	7.1 n=18
2. 25-34 years old	71.6 n=17	15.4 n=16
3. 35-44 years old	98.8 n=17	22.5 n=16
4. 45-64 years old	276.1 n=19	18.9 n=22
5. 65 or older	286.3 n=18	15.0 n=24
6. Missing		

A4. CLIENT DISABILITY TYPE	1 Mean Numbers on Dec. 31, 1992	2 Estimated Percentage of SSI disabled (%)
1. Mentally Retarded/ Developmentally Disabled (MR/DD)	855.8 n=12	9.6 n=10
2. Mentally Ill (MI)	779 n=9	43.9 n=11
3. Physically Disabled (PD)	55.5 n=11	54.0 n=9
4. Other (Please specify) Blind	1241.8 n=8	.125 n=8

* The number of respondents equals 80 unless otherwise specified.

B. Consumer Satisfaction

B1. Do you use surveys or other formal measures to determine consumer satisfaction with your plan? (%)

16.3 1. No

78.8 2. Yes

1.3 3. Do not know

3.8 4. Missing

B2. What if any formal measures do you use, please specify: (%)

20.0 1. Mailed Survey

12.5 2. Telephone Survey

12.5 3. In-clinic Questionnaire

11.3 4. Telephone and Mail Questionnaire

10.0 5. Mail and In-clinic Questionnaire

3.8 6. Telephone and In-clinic Questionnaire

2.5 7. Other

27.5 8. Missing

How many do you survey? (%)

40.0 1. Sample

16.3 2. All

1.3 3. Other

42.5 4. Missing

* The number of respondents equals 80 unless otherwise specified.

How often do you survey? (%)

25.0 1. Annually

12.5 2. Variable

8.8 3. Quarterly

7.5 4. Bi-annual

6.3 5. Dual schedules

5.0 6. Once every two years

3.8 7. Monthly

3.8 8. Other (please specify)

27.5 9. Missing

B3. On average, how satisfied are the following groups with your plan? (%)

	Very Satisfied	Somewhat Satisfied	Not Very Satisfied	Not Satisfied	Do Not Know	N/A	Missing
1. SSI disabled clients	26.2	32.5	0.0	0.0	37.5	0.0	3.8
2. Organizations that advocate for the disabled	12.5	23.8	2.5	0.0	56.3	1.3	3.8
3. AFDC clients n=69	36.3	27.5	1.3	0.0	21.3	0.0	13.8

B4. During the last 12 month reporting period, how many new AFDC recipients enrolled in your plan?

n=35, mean=7325

B5. During the last 12 month reporting period, how many new SSI disabled adult recipients enrolled in your plan?

n=35, mean=435

* The number of respondents equals 80 unless otherwise specified.

B6. During the last 12 month reporting period, how many AFDC recipients voluntarily disenrolled from your plan?

n=40, mean=1530

B7. During the last 12 month reporting period, how many SSI disabled adult recipients voluntarily disenrolled from your plan?

n=46, mean=142

III. MARKETING AND SERVICE DELIVERY

In this section of the questionnaire, we would like to know how you market your managed care plan. We are also interested in your experiences in providing plan services.

A. Marketing

A1. What have been the three most effective strategies for enrolling AFDC and SSI disabled consumers in your plan? [For each column, please check only three strategies] (%)

Marketing strategy	AFDC clients	SSI clients
1. Mass media	12.5 n=10	12.5 n=10
2. Mailings	17.5 n=14	18.8 n=15
3. Door to door	28.8 n=23	26.2 n=21
4. Contacting advocacy groups	11.3 n=9	10.0 n=8
5. Contacting providers known to serve this population	18.8 n=15	18.8 n=15
6. Contact through the local welfare office	47.5 n=38	40.0 n=32
7. Contact through the local social security office	7.5 n=6	13.8 n=11
8. None needed, enrollment mandatory	17.5 n=14	22.5 n=18

* The number of respondents equals 80 unless otherwise specified.

9. Other

Do not market	6.3 n=15	7.5 n=15
Do not know	0.0 n=15	1.3 n=15
Yes	12.5 n=15	17.5 n=15

(Please Specify)
Directly contacting clients of MH center
Grass roots Marketing in community
SSI clients

A2. What incentives does your state create for you to enroll and offer services to SSI disabled adults? (%)

21.3 1. Higher capitation rate

6.3 2. State mandate

6.3 3. Receiving regular capitation payments

5.0 4. Do not know

3.8 5. Increase enrollment

3.8 6. Other
Indirect financial incentives
No incentive

2.5 7. Offer more services

52.5 8. None

* The number of respondents equals 80 unless otherwise specified.

A3. What disincentives does your state impose causing you to restrict enrollment and services to SSI disabled adults? (%)

15.0 1. Capitation rate not high enough

12.5 2. Other
Mandatory group must be covered
Requirement to carry the risk for all outpatient emergency room needs
High medical costs and extra services required

8.8 3. Exclusions

2.5 4. Do not know

61.3 5. None

B. Service Delivery

B1. Now we'd like to compare service delivery for AFDC and SSI disabled clients. I'll read several statements and would like to know for each of if how would you describe providing managed care services to the SSI disabled population in comparison to the AFDC population on the following issues? (Please check column 1 if statement BETTER DESCRIBES THE AFDC POPULATION, check column 2 if it BETTER DESCRIBES THE SSI DISABLED POPULATION, and check column 3 if there is NO SIGNIFICANT DIFFERENCE between the two groups of Medicaid managed health care clients.)

Statement	1 Better Describes AFDC Clients	2 Better Describes SSI clients	3 No Difference	4 Do not know	5 N/A	6 Missing
1. Clients use more primary care services.	27.5	17.5	20.0	20.0	1.3	13.8
2. Clients use more specialty services.	6.3	48.8	12.5	18.8	0.0	13.8
a. Hospital inpatient	8.8	42.5	15.0	20.0	0.0	13.8
b. Emergency services	35.0	13.8	18.8	18.8	0.0	13.8
c. Dental care	18.8	7.5	16.3	26.2	16.3	15.0

* The number of respondents equals 80 unless otherwise specified.

Statement	1 Better Describes AFDC Clients	2 Better Describes SSI clients	3 No Difference	4 Do not know	5 N/A	6 Missing
d. Psychiatric hospitalization	12.5	27.5	21.3	25.0	0.0	13.8
e. Outpatient psychotherapy	16.3	25.0	18.8	22.5	3.8	13.8
f. Substance abuse treatment	21.3	17.5	18.8	25.0	3.8	13.8
g. Family planning	52.5	1.3	10.0	20.0	2.5	13.8
3. Clients require more coordination of non-medical services	8.8	35.0	21.3	20.0	1.3	13.8
4. Clients need more support services.	6.3	37.5	21.3	20.0	1.3	13.8
5. Clients require more costly services.	2.5	43.8	18.8	20.0	0.0	15.0
6. Physicians report fewer problems serving this population.	13.8	17.5	32.5	22.5	0.0	13.8
7. Health care providers other than physicians report fewer problems serving this population.	16.3	15.0	30.0	23.8	1.3	13.8

* The number of respondents equals 80 unless otherwise specified.

B2. Was your existing service delivery network adequate to meet the needs of the SSI disabled adult population at the time they began to join your plan? (%)

18.8 1. No

70.0 2. Yes (Go to B4)

7.5 3. Do not know

3.8 4. Missing

B3. If no, what modifications in your service delivery network were needed? (%)

6.3 1. Support services

6.3 2. Increase specialty physicians

5.0 3. Alternatives to hospitalization

2.5 4. Increase primary care physicians

2.5 5. Add case managers

1.3 6. Provide transportation

0.0 7. Other

81.3 8. Missing

B4. Do you find it necessary to routinely refer adult SSI disabled patients to out-of-plan providers? (%)

80.0 1. No

10.0 2. Yes (Please specify)

6.3 3. Do not know

3.8 4. Missing

B5. Who coordinates care for SSI disabled adults enrolled in your plan? [Check all that apply] (%)

75.0 1. Primary care physician

46.3 2. Within-plan case manager

11.3 3. Nurse practitioner or physician's assistant

* The number of respondents equals 80 unless otherwise specified.

6.3 4. Other (Please specify the types of providers)
Medical Management Division of Plan
Contract Health Services Personnel
Social Worker
Problem Case Management Teams

3.8 5. Do not know

B6. Are any providers in your plan who serve Medicaid recipients allowed to refuse to serve SSI disabled clients? (%)

82.5 1. No

8.8 2. Yes (please specify)
If they don't have expertise
Based on enrollment limits set by providers

5.0 3. Do not know

3.8 4. Missing

B7. Are there providers who tend to see a disproportionate number of SSI disabled enrollees? (%)

50.0 1. No (Go to B9)

31.3 2. Yes

13.8 3. Do not know

1.3 4. N/A

3.8 5. Missing

B8. If yes, what are some reasons for this? [Check all that apply] (%)

15.0 1. Provider choice

2.5 2. Certain providers are assigned

10.0 3. Certain providers have worked with this population in the past

13.8 4. Consumer choice

13.8 5. Location

10.0 6. Accessible office

* The number of respondents equals 80 unless otherwise specified.

8.8 7. Other (Please specify)
MCEP Plan
Many specialists present at one site
According to medical specialties they need

1.3 8. Do not know

B9. How have advocacy groups, in general, affected your ability to provide services to the SSI disabled? Please check if you STRONGLY AGREE, AGREE, DISAGREE or STRONGLY DISAGREE with the following statements. (%)

Role of Advocacy Groups	Strongly Agree	Agree	Disagree	Strongly Disagree	Do Not Know	N/A	Missing
1. They have improved the visibility of the plan in the disability community.	2.5	20.0	12.5	15.0	45.0	1.3	3.8
2. They have assisted us in tailoring services for the SSI disabled population.	3.8	13.8	21.3	18.8	37.5	1.3	3.8
For:							
a.the MR/DD population	1.3	11.3	16.3	17.5	42.5	6.3	5.0
b.the mentally ill population	3.8	7.5	20.0	18.8	43.8	1.3	5.0
c.the physically disabled population	2.5	15.0	15.0	17.5	41.3	3.8	5.0
3. Advocacy groups demand more services for SSI disabled adult clients than we can afford to provide.	5.0	15.0	22.5	7.5	45.0	1.3	3.8

* The number of respondents equals 80 unless otherwise specified.

Role of Advocacy Groups	Strongly Agree	Agree	Disagree	Strongly Disagree	Do Not Know	N/A	Missing
4. They threaten us with legal action if we do not go along with their demands.	1.3	10.0	30.0	13.8	40.0	1.3	3.8
5. They assist SSI clients to obtain the services we do offer.	3.8	30.0	15.0	6.3	40.0	1.3	3.8
6. They present a fair representation of the needs of SSI disabled adults.	1.3	31.3	6.3	5.0	51.3	1.3	3.8
7 Advocacy groups have had no effect on the plan's ability to serve the SSI disabled.	12.5	25.0	20.0	5.0	32.5	1.3	3.8

B10. Please list the advocacy groups that have assisted your clients. (%)

31.3 1. At Least One
ARC
Center for Law
Navajo Tribe
Community United Way
AMI

65.0 2. None

3.8 3. Missing

* The number of respondents equals 80 unless otherwise specified.

IV. FINANCIAL STRUCTURE AND DATA REPORTING CAPABILITIES

In this section of the questionnaire, we are interested in obtaining financial and data reporting information about your managed care plan.

A. Financial Structure

A1. What services are offered by your plan? What services that you offer are included in the capitation payment that you receive from the state? Please check column 1 if the service is OFFERED by your plan. Then check column 2 if the service is INCLUDED in your capitation payment.

	1 Offered	2 Included in capitation
1. Primary Care Office Visits	92.5	80.0
2. Hospital Inpatient	88.8	68.8
3. Hospital Outpatient	91.3	78.8
4. Lab Services	93.8	82.5
5. Emergency Services	95.0	81.3
6. Intermediate Care	73.8	60.0
7. Federally Qualified Health Centers	53.8	40.0
8. Skilled Nursing Care	75.0	58.7
9. Outpatient Psychotherapy	81.3	73.8
10. Group Psychotherapy	71.3	63.8
11. Partial Hospitalization	63.8	45.0
12. Day Treatment	62.5	55.0
13. Respite Care	32.5	23.8
14. Substance Abuse Treatment	72.5	50.0
15. Detoxification	71.3	52.5
16. Family Planning	87.5	73.8

* The number of respondents equals 80 unless otherwise specified.

	1 Offered	2 Included in capitation
17. Eye Exams	86.3	70.0
18. Eyeglasses	75.0	57.5
19. Personal Assistance Services	47.5	30.0
20. Hospice care	62.5	42.5
21. Other (Please specify)	40.0	28.8
22. Occupational Therapy	81.3	66.3
23. Physical Therapy	88.8	72.5
24. Speech Therapy	82.5	67.5
25. Prescriptions	88.8	75.0
26. Medical Monitoring	91.3	81.3
27. Case Management	92.5	75.0
28. Prosthetics	81.3	66.3
29. Durable Medical Equipment	86.3	72.5
30. Dental Care	55.0	37.5
31. Dentures	45.0	31.3
32. Chiropractic Care	55.0	42.5
33. Podiatry	83.8	67.5
34. MIV Testing	91.3	73.8
35. Psychiatric Hospital	85.0	67.5

* The number of respondents equals 80 unless otherwise specified.

A2. How are your capitation rates determined? [Please check only one] (%)

53.8 1. State sets rates

41.3 2. Rates are negotiated between plan and state

0.0 3. Plan sets rates

1.3 4. Do not know

3.8 5. Missing

A3. Was the plan given the opportunity to negotiate the capitation rates with the state? (%)

60.0 1. Yes

35.0 2. No

1.3 3. Do not know

3.8 4. Missing

A4. Are your capitation rates different for AFDC and SSI disabled enrollees? (%)

71.3 1. Yes

13.8 2. No

1.3 3. Do not know

13.8 4. Missing

* The number of respondents equals 80 unless otherwise specified.

A5. Are your capitation rates differentiated by the following categories? [Please check all that apply] (%)

42.5 1. Age-based rates
n=35

30.0 2. Gender-based rates
n=25

21.3 3. Disability-based rates. Please check any of the following disability categories that are differentiated:

1.3 a. MR/DD
n=2

0.0 b. Mentally ill
n=1

5.0 c. Physically Disabled
n=5

16.3 d. AIDS
n=14

1.3 e. Diabetes
n=2

0.0 f. Heart disease
n=1

0.0 g. Cancer
n=1

7.5 h. Other (Please specify)
n=7
Elderly
Blind and SSI Disabled
Medjcally Needy vs. Public Assistance

73.8 4. Other (Please specify)
n=60
Based on income of enrollees
Based on category and on county
Geographic distribution

1.3 5. Do not know

A6. Based on your experiences serving Medicaid recipients, please indicate the adequacy of current capitation rates for the following groups. (%)

Groups	Very Adequate	Somewhat Adequate	Not Very Adequate	Not At All Adequate	Do Not Know	N/A	Missing
1. All AFDC clients	8.8	48.8	18.8	12.5	5.0	0.0	6.3

* The number of respondents equals 80 unless otherwise specified.

Groups	Very Adequate	Somewhat Adequate	Not Very Adequate	Not At All Adequate	Do Not Know	N/A	Missing
2. All SSI disabled adults served by this plan	3.8	51.3	18.8	15.0	7.5	0.0	3.8
3. MR/DD SSI disabled adults	2.5	21.3	15.0	13.8	31.3	12.5	3.8
4. Mentally ill SSI disabled adults	2.5	32.5	13.8	17.5	30.0	0.0	3.8
5. Physically disabled SSI adults	3.8	35.0	13.8	12.5	30.0	1.3	3.8

A7. What is the predominant method used by your plan to pay individual physicians for primary care services? For specialty services? (%)

	Primary Care Services n=73	Specialty Services n=75
1. Payment is capitated.	38.8	3.8
2. Payment is fee-for-service.	20.0	70.0
3. Physicians are salaried.	23.8	11.3
4. Payment is capitated and payment is fee-for service.	0.0	0.0
5. Payment is fee-for service and physicians are salaried.	0.0	3.8
6. Payment is capitated and physicians are salaried.	3.8	0.0
7. Payment is capitated, payment is fee-for-service and physicians are salaried.	2.5	2.5
8. Do not know	1.3	1.3

* The number of respondents equals 80 unless otherwise specified.

	Primary Care Services n=73	Specialty Services n=75
9. N/A	1.3	1.3
10. Missing	8.8	6.3

Capitated plans often purchase stop/loss insurance to protect themselves from risk. Questions A8 to A10 concern this insurance.

A8. Does the plan have a stop/loss agreement with the state or a private insurer? (%)

38.8 1. The State.

20.0 2. A private insurer.

6.3 3. Other (please specify)
Self insured
Both state and stop/loss contract with private insurer

28.8 4. The plan has no stop/loss agreement.

2.5 5. Do not know

3.8 6. Missing

A9. Is your stop/loss agreement the same for all categories of Medicaid enrollees? (%)

12.5 1. No

50.0 2. Yes, If Yes, please specify level

5.0 3. Do not know

32.5 4. Missing

If No, What are the levels for each category?
(cell size too small for reporting)

* The number of respondents equals 80 unless otherwise specified.

A10. Is your stop/loss insurance based on individual consumer's utilization or on aggregate levels of utilization? (%)

50.0 1. Individual consumers (Go to A11)

10.0 2. Aggregate utilization (Go to A12)

2.5 3. Other (Please describe):
Both

5.0 4. Do not know

32.5 5. Missing

A11. In the last 12 month reporting period, what percent of Medicaid recipients who exceeded your stop/loss level were:

in the AFDC category?
n=22, mean=10.6

in the SSI disabled category?
n=23, mean=17.7

A12. With whom do individual primary care physicians share the financial risk for losses or surpluses associated with specialty care? (%)

36.3 1. Financial risk is not shared

15.0 2. Shared by all HMO physicians

8.8 3. Shared by physician subgroup

1.3 4. Assumed by individual subgroup

30.0 5. Other (Please specify)

2.5 6. Do not know

1.3 7. N/A

5.0 8. Missing

* The number of respondents equals 80 unless otherwise specified.

B. Data Reporting

B1. Is the level of complaints by SSI disabled adults GREATER THAN or LESS THAN complaints of AFDC enrollees? (%)

8.8 1. Greater than

27.5 2. Less than

31.3 3. About the same

18.8 4. Do not know

13.8 5. Missing

B2. How frequently are any of the following service decisions appealed by SSI disabled adult enrollees? (%)

Service decision	Very Frequently	Somewhat Frequently	Not Very Frequently	Not At All	Don't Know	Missing	N/A
1. Denial of specialist referrals	1.3	1.3	42.5	23.8	25.0	5.0	1.3
2. Denial of requests for durable medical equipment	0.0	5.0	37.5	23.8	25.0	5.0	3.8
3. Hospital length of stay	0.0	2.5	26.2	40.0	26.2	5.0	0.0
4. Procedure location - outpatient v. inpatient	0.0	2.5	32.5	33.8	26.2	5.0	0.0
5. Mental health services issues	0.0	5.0	40.0	20.0	28.8	5.0	1.3

* The number of respondents equals 80 unless otherwise specified.

B3. Does your data system track service utilization on a person-specific basis? (%)
n=77

20.0 1. No

71.3 2. Yes

5.0 3. Do not know

3.8 4. Missing

B4. Does your data system allow you to identify service utilization for each of the following categories of Medicaid enrollees in your program? [Please check all that apply] (%)

65.0 1. AFDC clients
n=54

66.3 2. SSI disabled adults in general
n=58

11.3 a. MR/DD clients
n=15

20.0 b. Mentally ill clients
n=22

13.8 c. Physically disabled clients
n=17

B5. a. Do you enroll disabled clients who are eligible for both Medicare and Medicaid? (%)

13.8 1. No

81.3 2. Yes

1.3 3. Do not know

3.8 4. Missing

b. Please explain why you do or do not enroll this population. (%)

55.0 1. State mandate

18.8 2. Non-selective enrollment

7.5 3. Medicare program

* The number of respondents equals 80 unless otherwise specified.

6.3 4. Other
Tribal members
Can handle them in same way as SSI can bill Medicare
To raise membership

5.0 5. Financial incentive

2.5 6. No administrative difference

1.3 7. Increase membership

1.3 8. Do not know

7.5 9. Missing

B5. c. If you do enroll dually eligible clients, does this group present additional challenges to your plan? Please describe. (%)

40.0 1. No

38.8 2. Yes
(n=39)

5.0 a. Additional benefits eligibility

6.3 b. Continuity of care problems

21.3 c. Coordination of benefits

2.5 d. Identifying them

6.3 e. Complex cases

3.8 f. Two plan enrollment

1.3 g. Prescription abuse

2.5 h. Other

2.5 3. Do not know

18.8 4. Missing

* The number of respondents equals 80 unless otherwise specified.

B6. What is working well in terms of your plan providing services to the SSI disabled population? (%)

33.8 1. CM Coordinator

15.0 2. Do not know

11.3 3. Innovative Programs for Population

11.3 4. Accessibility

11.3 5. Other
Lenient, small plan-listen to needs of people
Don't identify them as a separate population

8.8 6. Full range of services

3.8 7. Increase access to providers

6.3 8. Nothing

7.5 9. Decrease hospital use

7.5 10. Good network of physicians

B7. What changes or improvements would you like in your program for this population? (%)

17.5 1. Expand services

16.3 2. Do not know

16.3 3. None

15.0 4. Other

13.8 5. Higher capitation rate

10.0 6. Expand eligibility categories

5.0 7. Coordinate services better

7.5 8. Educate consumers and providers better

5.0 9. Increase enrollment

3.8 10. Good data systems

1.3 11. More freedom to market

* The number of respondents equals 80 unless otherwise specified.

B8. What do you see as the future for your plan in terms of providing services to the SSI disabled population? [Check all that apply]. (%)

Plan will:

53.8 1. Continue as it is

40.0 2. Increase number of enrollees

15.0 3. Increase range of services

2.5 4. Restrict number of future SSI disabled enrollees

1.3 5. Stop serving population

18.8 6. Other (Please specify)
Start working at specific populations
Wait to see new federal reforms
Decrease services due to lack of resources
Increase types of settings

3.8 7. Do not know

B9. What would your advice be to managed care plans considering enrolling the SSI disabled? (%)

17.5 1. Adequate cap

17.5 2. Good network of physicians

17.5 3. Good case management

12.5 4. Good data systems

12.5 5. Understand needs of population

11.3 6. Do not know

8.8 7. Openly treat them

6.3 8. Aware of mental health issues

6.3 9. Importance of client selection

3.8 10. Educate consumers on pros and cons

3.8 11. Other

6.3 12. Go slow be careful

* The number of respondents equals 80 unless otherwise specified.

B10. What could the state do to facilitate improved services to this group? (%)

17.5 1. Increase capitation

13.8 2. Expand services

6.3 3. Educate clients of plan

5.0 4. Identify clients for plan

6.3 5. Expand eligibility

6.3 6. Educate plan

3.8 7. Carve out special populations

2.5 8. Coordinate funding better

2.5 9. Improve access to provider

1.3 10. Improve client transportation

6.3 11. Other

17.5 12. Do not know

* The number of respondents equals 80 unless otherwise specified.

B11. Please identify barriers to enrolling the SSI disabled population in your plan. (%)

36.3 1. None

15.0 2. Client disability/special needs of clients

10.0 3. Changing provider relationship

8.8 4. Eligibility issues

8.8 5. Do not know

8.8 6. Marketing to population

6.3 7. Transportation

3.8 8. State issues

3.8 9. Access to provider

2.5 10. Higher cost

1.3 11. Other
Don't know who is SSI disabled or AFDC
Lack of adequate MH services for CMI
Lack of doctors who accept Medicaid

* The number of respondents equals 80 unless otherwise specified.

C. Plan Administrator Characteristics

C1. Title (%)

23.8 1. CEO

28.8 2. Vice President

3.8 3. Marketing People

7.5 4. Financial People

2.5 5. Medical

12.5 6. Case Manager

17.5 7. Government Contract

1.3 8. Other

2.5 9. Missing

C2. Number of years with the plan

n=77, mean=6.1

C3. Number of years in managed care

n=77, mean=8.0

* The number of respondents equals 80 unless otherwise specified.

C4. What is your highest level of education? (%)

0.0 1. High school diploma or GED

5.0 2. Some college

16.3 3. College degree

17.5 4. Some graduate school

5. Other degree

7.5 a. R.N. degree

28.8 b. Master's degree

2.5 c. C.P.A.

5.0 d. Ph.D.

7.5 e. M.D.

5.0 f. Other (Please specify)
Law
ARRT, MLT
Licensed Nursing Home Administrator

5.0 6. Missing

C5. Which of the following age categories best describes you? (%)

1.3 1. 18-24

17.5 2. 25-34

37.5 3. 35-44

37.5 4. 45-64

1.3 5. 65 and older

5.0 6. Missing

* The number of respondents equals 80 unless otherwise specified.

C6. Are you: (%)

53.8 1. Female

46.3 2. Male

Your participation in this study is greatly appreciated. Thank you for your help.

* The number of respondents equals 80 unless otherwise specified.

APPENDIX C

Medicaid Managed Care for the SSI Disabled Population:

A Review of the Literature

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INTRODUCTION

For more than twenty years, rapidly rising costs have kept the United States health care system in a chronic state of financial crisis. In 1988, for example, spending for health amounted to 11.1 percent of the gross national product, more than twice the share it commanded in 1960. In 1989, the nation's spending on health care climbed to more than $604 billion, resulting in an average expenditure of approximately $2,400 per person. By 1990, total expenditures exceeded $660 billion or roughly 12 percent of the gross national product. The Commerce Department expects that if this pattern is maintained, spending for health care will increase at an annual rate of between 12 and 15 percent for the next five years. Contributing to these increases in overall spending for health care has been the dramatic growth in total Medicaid expenditures. From 1975 to 1990, total Medicaid payments have grown from $12.2 billion to $66 billion (Reilly, Clauser & Baugh, 1990). General Accounting Office (GAO) estimates for Fiscal Year 1992 expect Medicaid expenditures to reach $127.2 billion, a 38 percent increase from the 1991 figure of $92.2 billion which reflects a record enrollment figure of 30.1 million Medicaid recipients (Shikles, 1992).

Managed Health Care as a Cost Control Solution

The continual growth of health care costs has forced private insurance companies and government agencies to search for ways to contain expenditures while maintaining or improving access to quality care (Bachman, 1992; Freund & Hurley, 1987). One approach has been to develop a variety of managed care models. Managed care is a coordinating and rationing strategy designed to make the unique "gatekeeping" role of a primary care professional the key to cost control (Freund & Hurley, 1987). In essence, the primary care professional or care

manager influences health care delivery by assessing the appropriateness of care for each individual prospectively or retrospectively.

Despite the ever increasing variety of managed health care models in existence, managed care is often equated with capitated plans. However, managed care fee-for-service plans are presently the largest segment of the managed care industry (Curtis, 1989). The key differences between these two managed care strategies are important to note. Under full capitation systems, the provider organization receives a prepayment which covers either all or a defined group of the health services provided to an individual over a set period of time. The most common providers of capitated health care are Health Maintenance Organizations (HMO). With this strategy, the HMO assumes full financial risk for all the covered services consumers need, resulting in incentives for providers to promote preventive care and avoid delivering unnecessary services. A risk of underservice (Liu, 1992; Melden, 1992) and a biased selection of healthier enrollees (Wallack, 1991) also exist with this model. In contrast, in managed care fee-for-service plans each service is usually paid for separately, on a retrospective basis, thereby giving individual providers fewer incentives to decrease their volume of service. Cost containment strategies used in fee-for-service models include utilization review of hospital admissions and lengths of stay (Curtis, 1989), care management for high cost consumers (Wallack, 1991) and restrictions on recipients in their choice of a primary care provider (Hurley & Freund, 1991). A range of other managed care models blends features of both of these strategies, usually providing prepayment for some, not all, services and offering providers opportunities for various approaches for risk-sharing (Hurley & Freund, 1991).

Medicaid Involvement in Managed Health Care

Medicaid Eligibility Categories

The Medicaid program is designed to cover poor and near poor individuals who fall into one of three broad eligibility groups (Social Security Bulletin, September 1991). The largest category includes children and adults from low income families who are part of the Aid for Families with Dependent Children (AFDC) program. Although AFDC recipients constituted 68 percent of Medicaid recipients in 1989, payments for their medical expenses totaled only 25 percent of all payments (Social Security Bulletin, September 1991).

The second largest category is made up of the low income population of persons with disabilities. This group is composed primarily of persons with visual and other disabilities who receive cash assistance through the Supplementary Security Income (SSI) program. Although this group constituted only 15.3 percent of all Medicaid enrollees in 1989, their payments were the largest proportion of total Medicaid payments (38.3 percent) (Social Security Bulletin, September 1991). In fact, payments for persons with disabilities accounted for 42 percent of the total growth in Medicaid payments between 1975 and 1989, an increase from 3 billion to over 20 billion dollars (Reilly et al., 1990). During this period, the number of Medicaid enrollees with disabilities increased by 46 percent, from 2.46 to 3.59 million. In contrast, the total Medicaid recipient count increased by less than seven percent during the same period (Reilly et al., 1990). The third category of Medicaid recipients includes the low income aged who make up 13.3 percent of the Medicaid population. Similar to the low income population of persons with disabilities, the aged group accounted for a disproportionately large share (34.1 percent) of total Medicaid payments in 1989 (Social Security Bulletin, September 1991).

Federal Support for Development of Medicaid Managed Care Approaches

Demands for cost control have prompted increasing involvement of Medicaid and Medicare in the delivery of managed care services (Bachman, 1992; Firshein, 1992; Shikles, 1992). In 1981 through the Omnibus Budget Reconciliation Act (OBRA), the federal government promoted state-level development of Medicaid managed care plans. OBRA created a waiver process for states to request release from certain Medicaid requirements, including freedom of choice (i.e. those provisions of the law that give Medicaid recipients the "freedom to choose" from among all Medicaid providers in the state). These options have been successful in encouraging the development of state Medicaid managed care approaches. For example, as of June 1992, at least 44 states and the District of Columbia offered one or more managed care plans for Medicaid beneficiaries (HCFA, 1992). Although Medicaid managed care enrollment rates are lower than that for the private sector managed care population (Booth, Coburn & Riley, 1993; Iglehart, 1992; Moley, 1992), they have increased progressively during the last decade to about 12 percent of all Medicaid recipients. Forty-five percent of these beneficiaries are enrolled in managed care fee-for-service programs, 34 percent in HMOs and 19 percent in a range of other managed care models (Shikles, 1992). A majority of Medicaid managed care enrollees are young AFDC recipients or relatively healthy older persons (Anderson & Fox, 1987; HCFA, 1990).

Recent federal legislative initiatives (Senate Bill 3191, Medicaid Managed Care Improvement Act of 1991) have been proposed which, if passed, would further reduce the administrative barriers state Medicaid officials face in planning and developing managed care plans (e.g. complex and unwieldy waiver application processes, erratic Medicaid enrollment

patterns [Baird, 1992]). Certain aspects of expert testimony for and against passage of the bill are noteworthy and are indicative of the evolution of managed care practice in the United States. In general, testimony was suggestive of wide acceptance of the usefulness and inevitability of managed care approaches (Baird, 1992; Bellber, 1992; Moley, 1992; Pelrine, 1992; Watson, 1992), even though several constituency groups (i.e. Children's Defense Fund and National Health Law Program) expressed serious reservations about some of Senate Bill 3191's provisions (Liu, 1992; Melden, 1992). These consumer advocates recommended a heightened, rather than diminished, federal oversight role with state-level Medicaid managed care plans, focused on protection of the interests of low income populations and persons with disabilities. The National Task Force on Medicaid Managed Care (Booth et al., 1993) concurred with their endorsement of the development of federal guidelines, similar to those employed with the Medicare program, to reduce state-by-state inequities related to critical issues, such as accessibility, quality assurance and provider reimbursement structures.

Types of Medicaid Managed Care

The managed care plans which have been offered to the Medicaid population differ along the dimensions of payment approach and enrollment model. First, programs can be distinguished across a continuum of prepayment versus fee-for-service payment strategies. Capitated models of managed care (e.g. HMO) are the original and most widespread type of Medicaid managed care prepayment program. With capitated plans, the provider receives a pre-determined payment in exchange for assuming full or partial responsibility/risk for providing a pre-determined set of covered health services for individual consumers. States are also developing alternative managed care programs which are less dependent on capitation. Hurley

& Freund (1991) classified the Medicaid managed care programs they examined into 3 major typologies:

- Type 1--a fee-for-service primary care case manager (PCCM) model;
- Type 2--an at risk (capitation) PCCM model; and
- Type 3--a (capitation) prepaid health plan model.

In the Type 1 fee-for-service PCCM arrangement, the state Medicaid agency or Health Insurance Organization (HIO) contracts with individual physicians or physician groups to provide primary care to Medicaid recipients and to authorize (as a "gatekeeper") all other covered services provided by others. Typically, contracted physicians are provided an additional case management fee. The Type 2 at risk (capitation) PCCM arrangement involves some risk-sharing for contracted physicians/ physician groups via capitation payments for primary care services and sharing in losses or gains related to use of outside providers/ services. The Type 3 arrangement, the prepaid health plan model, involves the assumption of full responsibility for all covered services by prepaid health plan organizations (HMOs). The range of care management (CM) payment methods includes: fee-for service, fee-for-service plus CM fee, fee-for-service with shared savings, capitation with shared savings and full capitation.

A second dimension of Medicaid managed care programs pertains to the enrollment model which may be either voluntary or mandatory. In some states, Medicaid recipients can choose whether or not they want to participate in a managed care program. In other states, Medicaid enrollees are required to participate, although they may usually choose from among more than one plan option. Further, in some states, participation is only mandatory for selected categories of Medicaid recipients or for persons in particular geographic areas (HCFA, 1992).

EVALUATION OF MANAGED CARE FOR THE GENERAL POPULATION AND FOR THE GENERAL MEDICAID POPULATION

Various studies have been conducted to test whether managed care plans in general accomplish their purported goals. For example, in comparison to persons in traditional fee-for-service plans, Luft (1981) found that members of capitated managed care plans experienced significantly lower per capita health care costs as a result of fewer per capita hospital admissions. Importantly, these changes were not accompanied by any declines in either mortality or morbidity. Manning, Leibowitz, Goldberg, Rogers and Newhouse (1984) conducted a controlled study in which individuals were randomly assigned to an HMO or a traditional fee-for-service plan. The authors reported lower rates of hospital admissions and fewer hospital days for HMO enrollees.

Findings from the RAND Health Insurance Experiment provide some evidence that capitated managed care approaches may have detrimental effects for persons in poor health. In a three year study of low income adults enrolled in an HMO, Ware, Brook, Rogers et al. (1986) found that those in poor health prior to enrollment had less favorable outcomes than individuals in poor health in the fee-for-service comparison group. Therefore, it is not clear whether the success of managed care has resulted from effective management or from client selection (Freund & Hurley, 1987).

Although scientific findings are limited and highly speculative, the results indicate that for relatively young and healthy members of the general population, capitated managed care models have been successful in controlling health care costs while still providing quality

services. To date, however, participation in capitated plans has generally been available as a benefit of full-time employment only to this younger, healthier segment of the population.

Other studies conducted to test the effects of managed care plans for primarily the AFDC child and adult Medicaid population have also resulted in highly inconclusive scientific findings. The following section describes limitations of these evaluation studies, summarizes what has been learned from the experiences of states thus far and outlines what needs to be investigated further regarding Medicaid managed care for the general population. With respect to the limitations of these evaluation studies, the findings are based on data of uneven quality (Hurley & Freund, 1991). Few of the original studies are methodologically sound. Some studies, designed specifically to demonstrate the cost effectiveness of Medicaid managed care approaches (e.g. those accompanying waiver applications), are inherently biased. Most studies are cross-sectional and capture the first years of a state's experience. They fail to provide a clear picture of program implementation over a sustained period of time. The focus of most studies is limited to the AFDC child and adult population. While service utilization patterns and cost impacts have received the lion's share of attention, reliable information about other important issues, such as, quality of care, consumer satisfaction and the presence of biased selection enrollment patterns is noticeably lacking. Diverse program designs characterize the country's Medicaid managed care landscape, a natural and desired consequence of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (Hurley & Freund, 1990). However, this variety limits the ability of evaluators to identify refined and generalizable comparisons in their analyses of program outcomes (Shikles, 1993).

These limitations notwithstanding, the following studies provide the most scientifically rigorous knowledge base for understanding the effect of managed care on the general Medicaid population. Hurley and Freund (1991) have conducted the most extensive analysis to date of accumulated information about the variety and impact of Medicaid managed care approaches. The authors were specifically interested in comparing methods of "gatekeeping" (i.e. designating a single point of entry for Medicaid recipients' access to primary care services and other "non-emergency" covered services). They analyzed data from state-sponsored internal/external program evaluations and federally sponsored evaluations, including Medicaid Competition Demonstrations (MCD), Medicaid Program Evaluation (MPE) and the Arizona Health Care Cost Containment System (AHCCCS), a total of 25 programs in 17 states. The focus of their examination of program outcomes was limited to service use and cost impact.

In an effort to deal with some of the limitations described earlier, Hurley and Freund (1991) developed a set of quality criteria for determining which studies to include. They analyzed a sub-set of the strongest data to substantiate their initial findings. Eight (8) of the 25 programs they examined used a fee-for-service primary care case manager (PCCM) enrollment model. A majority (11) of the programs used an at risk (partial capitation) PCCM enrollment model. Six (6) programs were classified as prepaid health plans (HMOs). Hurley and Freund examined cost impacts and service use (physician visits, ancillary services, prescription drugs, inpatient days, emergency department visits) to compare differences by program design. Although not all of the outcomes could be specifically attributed to the gatekeeping functions in the managed care plans, these researchers observed the following trends:

1. Eighty percent (80%) of the programs resulted in reduced Medicaid expenditures. Savings on a per AFDC recipient basis averaged 5-15%. Current data are inadequate in determining if providers were being underpaid or if service costs were actually being fully covered by Medicaid payments.

2. Few differences could be detected between mandatory and voluntary programs with respect to service use. However, voluntary programs realized fewer cost savings due to difficulties in developing large enough enrollments to balance their administrative expenses.

3. In a comparison of fee-for-service models (Type 1) with capitated models (Type 2 and Type 3), few significant differences were detected, with one exception. Relatively higher use of physician visits appear more likely with fee-for-service models. This finding provides crude evidence that financial incentives do influence "gatekeeping" practices, and also raises questions about whether capitated models were restricting consumer access for physician visits. All three program designs appear to lead to decreased use of emergency departments for non-emergency needs and to decreased use of ancillary care, prescription drugs and inpatient care.

Heinen, Fox and Anderson (1990) carried out an in-depth analysis of one of the aforementioned federal evaluations, the Medicaid Competition Demonstrations. Their review

highlights the results of HCFA-sponsored Medicaid managed care three year demonstration projects in five states initiated in 1983-84. Two of the projects were discontinued for financial, administrative and/or political reasons. The authors report that (1) the pool of managed care provider recruitment was limited in all sites, (2) few cost savings were realized by participating plans, (3) time allowances for start up were essential, and (4) most plan administrators were uneasy about the use of managed care approaches with vulnerable Medicaid populations (i.e. persons with disabilities).

Finally, Riley, Coburn and Kilbreth (1990) surveyed state Medicaid officials in 40 states and conducted follow-up site visits in 11 of these states to document current Medicaid managed care approaches in the United States and to elaborate problematic issues and future policy implications. They documented a variety of innovative planning approaches undertaken by state Medicaid agencies in the presence of difficult, and sometimes conflicting, federal policy constraints. The authors' recommendations include increased collaboration between state and federal policy makers to reassess current federal requirements (e.g. Medicaid waiver processes, Medicaid enrollment mix requirements, etc.) and to create standards for reimbursement rate structures that will provide incentives for managed care plan involvement with Medicaid populations, in particular with consumers having complex health and social needs.

Heinen et al. (1990), Riley et al. (1990), Shikles (1992) and Hurley and Freund (1991) have identified a multitude of pressing research and policy issues in need of further scientific investigation and national attention with respect to the impact of Medicaid managed care on consumers, providers and administering agencies. These include: quality of care, standardized data collection and management systems, quality assurance standards and monitoring

mechanisms, provider and beneficiary recruitment, continuity of eligibility, examination of the presence of biased selection enrollment patterns, rate-setting strategies including, stop-loss protections for providers, consumer satisfaction, and, service approaches with consumers having complex health and social needs, particularly in the nation's urban areas.

EVALUATION OF MEDICAID MANAGED CARE FOR SPECIAL POPULATIONS

Unique Issues for Special Medicaid Populations

This review also examines research regarding the effectiveness of managed care for non-elderly persons with disabilities, specifically, SSI recipients of working age enrolled in Medicaid managed care programs. These persons' unique health and social needs underscore the necessity for understanding the effectiveness of managed care approaches for serving them. A range of complex issues have been identified which need to be considered by health care providers and organizations who are designing managed care programs for individuals with disabilities. A summary of these complex issues follows. These persons often have established relationships with multiple specialists and may be willing to join a managed care plan only if these ties can be maintained (Heinen et al., 1990). They may have special needs which can best be served by specialists not associated with available managed care plans (Riley et al., 1990). Established HMOs may have limited experience dealing with Medicaid recipients having mental and/or physical disabilities (Anderson & Fox, 1987). In capitated programs, plan administrators may be concerned about high utilization and financial risk (Group Health Association of America, 1990). This difficulty is often compounded by a lack of sufficient cost and utilization data (Batavia et al., 1989). Since approximately 40-45 percent of persons in this special population

also receive Medicare (Adams, Ellwood & Pines, 1989), the financial management of a capitated program fully responsible for their health care needs is further complicated. Beyond the logistics of implementation, questions arise about how well these persons can be served in managed care programs as their health care needs often differ in critical ways from those of the general population (Meyers, 1990). In addition, clarity regarding how well managed care programs can serve individuals with chronic, as well as acute health care problems, is critical.

This review pays special attention to the three largest adult SSI disability categories: mental retardation/developmental disabilities, mental illness and physical disability. Similarities and differences are present in the needs of these three populations. For example, a substantial portion of individuals in each of these groups requires a range of health-related services much broader than those generally classified under acute care. Of particular relevance for those with developmental and physical disabilities are ongoing maintenance services, such as, occupational therapy, language therapy, physical therapy, personal assistance services, durable medical equipment and assistive devices. These services are generally not well covered under private insurance plans and Medicaid programs vary tremendously in their coverage of these services (Henderson, Howard & Strickler, 1991).

The treatment of serious and persistent mental illness requires careful monitoring of psychotropic medications, which have severe, and sometimes even life-threatening side effects. The need for substance abuse treatment is much higher among persons with mental illness than in the general population (Drake, Osher & Wallach, 1989; Safer, 1987). In addition, the scope of service needs for those with serious mental illness extends well beyond traditional acute mental health services (Lehman, 1987).

Finally, persons with severe physical disabilities are often highly susceptible to certain health problems, and many experience great difficulty in maintaining good health. For these individuals, a minor health problem can quickly become a major health dilemma (DeJong, Batavia & Griss, 1989; DeJong, Osberg, McGinnis, Seward, Branch & Campion, 1986; Meyers, Felton, Master et al.,1985). In addition, many persons with physical disabilities require an effective personal attendant to enable them to maintain a healthy and independent life (DeJong, 1979; 1981).

Given the range of health and support service they seek, it is clear that providing accessible and effective health care and related services to these three groups of persons with disabilities can be a challenging proposition which has enormous consequences for their well-being. Scientific assessments of the impact of managed care approaches in meeting the varied needs of these individuals, while containing expenditures, assume heightened importance.

Available Scientific Evidence

While managed care offers the promise of cost-effective, quality health care, little reliable information is at hand about the extent and effectiveness of Medicaid managed care programs for populations of SSI enrolled persons with disabilities. The following section describes the focus and limitations of available evaluation studies, summarizes what has been learned from these studies thus far and outlines what needs to be investigated further regarding Medicaid managed care for these special populations. The focus and limitations of most studies mirror those described in the previous section regarding studies of managed care with the general Medicaid population. For example, service utilization and health care expenditures command the greatest share of attention as outcome variables. However, some notice has been given to

other factors, such as health status outcomes and consumer satisfaction (Horwitz & Stein, 1990; Lurie, Moscovice, Finch, Christianson & Popkin, 1989; Meyers, Cupples, Lederman et al., 1987), as well as the effects of the availability of managed care on use of traditional community-based programs (Christianson, Lurie, Finch, & Moscovice, 1992).

Meyers (1990) highlighted the limitations of available studies in his detailed review of the literature. Fourteen of the seventeen studies reviewed, however, focused on the elderly and only three studies examined prepaid managed care plans. Few studies have been conducted with working age SSI enrolled persons with disabilities. In addition, studies of persons with disabilities in managed health care plans have involved "special" programs, such as intensive care coordination, rather than "generic" Medicaid managed care systems (e.g. Meyers et al., 1987). Evaluation studies are also limited by inadequate Medicaid data management systems which fail to allow for separate examination of certain groups of SSI enrolled persons with disabilities (Howard, 1991). Uneven quality, cross-sectional design, small sample sizes and inconsistency across studies are other factors limiting scientific understanding of the effects of managed care on SSI disabled populations (Howard, 1991; Meyers, 1990).

These limitations notwithstanding, Meyers' review found that in the few cases where costs or utilization were reduced, the reduction applied only to specific subsets of high risk populations and only to certain cost or utilization measures. For example, Meyers et al. (1987) found that for adults with major disabling conditions, those participating in the Independent Living-Primary managed care program experienced fewer longitudinal hospital days per person than did those in the comparison group. Another study of Medicaid beneficiaries voluntarily enrolled in an HMO found that more than 90 percent of the enrollees with disabilities reported

that HMO care was equal to or better than the care they had received in the fee-for-service sector. Notably, these positive experiences were accompanied by a decline in hospital admissions and total hospital days for the enrollees with disabilities (Fuller, Patera & Koziol, 1977).

Batavia et al. (1989) report the findings of a study carried out by the Research Program of the National Rehabilitation Hospital in Washington, D.C., to determine the feasibility of managed care for working age persons with physical disabilities. They determined that a capitated managed care model was too financially risky. They recommended use of a preferred provider fee-for-service approach.

Another important study, which compared the effectiveness of several Connecticut HMOs and traditional fee-for-service plans in serving children with chronic illnesses, concluded that neither do an adequate job. Horwitz and Stein (1990) noted that high financial risks for HMOs limited their willingness to care for these consumers. Traditional fee-for-service plans controlled their costs through service restrictions. Both types of plans used care management to control costs, rather than to encourage comprehensiveness and continuity of care.

A randomized, controlled demonstration project in Hennepin County, Minnesota focused on Medicaid recipients with serious and persistent mental illness is instructive on several fronts. Lurie et al. (1992) compared health and psychiatric outcomes of consumers enrolled in capitated managed care programs and traditional Medicaid fee-for-service plans. Most of the capitated plans used a PCCM approach to coordination of care. The demonstration project was discontinued after one year, however, due to the premature withdrawal of the largest capitated plan following financial losses related to adverse selection issues. No statistically significant

differences in health or psychiatric outcomes were identified between the experimental and comparison groups after the first year of the project. Some differences, reflecting decreases in functioning for enrollees in capitated plans, emerged a year later.

Christianson et al. (1992) examined the effects of this same demonstration project on capitated plan enrollees' use of traditional community-based mental health programs in Hennepin County. They reported little difference in use of these services. However, capitated plans absorbed significantly higher levels of write-offs for psychotherapy, drug therapy and day treatment than did traditional community-based fee-for-service Medicaid plans. Mechanic (1992) raises questions about whether care for persons with severe mental illness should be provided within existing managed care networks (a mainstreaming approach), or via specially designed managed care programs. He assesses the findings of Christianson et al. (1992) by noting that this study's limited focus on service utilization and write-offs with this mainstream model fails to address other important factors, such as long-term client outcomes and effects in communities without well-developed public sector mental health programs. Identifying several serious limitations of this study, he cautions against generalizing these findings to other communities.

Commenting on the same study by Christianson et al. (1992), Ferran (1992) underscores the complexity of effective service provision for consumers with serious and persistent mental illness and recommends more flexible and sensitive reimbursement strategies for providers, as well as the development of more effective treatment approaches (e.g. family support, group treatment, self-help, etc.). The report of Reed, Hennessy, Brown and Fray (1992) provides an example of innovative reimbursement and service approaches used within a specialized managed care program for persons with severe mental illness in New York State. Special features of the

program include: actuarily sound reimbursement rates, high staff/client ratio (one social worker to ten consumers with severe mental illness), flexible, individualized supports for consumers (e.g. discretionary use of funds for needs, such as housing and food). Positive outcomes reported were high provider satisfaction, lower inpatient readmissions and significant cost savings.

Meyers and Master (1989), Meyers (1990), Howard (1991), Mechanic (1992) and Ferran (1992) have identified major programmatic, administrative, financial and ethical issues which require rigorous investigation with respect to the effects of Medicaid managed care approaches with populations of persons having cognitive, developmental, physical and/or mental disabilities. Major stakeholders (federal and state Medicaid officials/policymakers, managed care plan administrators, service providers and consumer advocates) appear to be reluctant to assume that traditional managed care approaches will adequately address the complex health and social needs of these special populations without serious consequences. Broad areas for future research to assist policy and program development include methodologically rigorous investigations which assess:

1. A range of traditional and/or non-traditional service approaches that can contain costs while promoting favorable health/social short and long-term outcomes for persons with disabilities;

2. Implications for collaborations among existing community-based service systems and mainstream managed care programs;

3. Effects of gatekeeping approaches on access and health/social outcomes with these special populations;

4. Rate structures and payment mechanisms that will provide incentives for pre-paid plans to serve special populations;

5. State and national data management systems capable of tracking the experiences of managed care programs serving these special populations with respect to such factors as, enrollment selection patterns, service utilization, costs, quality of care, client outcomes, client and provider satisfaction.

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